THE HEALTH NEEDS OF THE GREEK CYPRIOT PEOPLE LIVING IN TWO LONDON BOROUGHS

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ABSTRACT

This study aimed to identify the health needs of the Greek Cypriots living in London by investigating their health and health behaviours and by comparing them with those of the indigenous population. The study also sought to discover whether health workers are able to meet these needs in a culturally sensitive and competent manner by assessing the level of information in their possession and their understanding of the Greek Cypriot culture and lifestyle, and its impact on health.

The study used both qualitative and quantitative methodologies for the collection and analysis of data. The two main methods used were the face-to-face interviews and the survey. A total of 358 individuals took part in the study.

The findings of the qualitative phase, provide a unique insight into the health beliefs, values and practices of the Greek Cypriots and indicate that culture is indeed an important influencing factor on health and lifestyles. The health and lifestyle survey provides statistical information which has not been available thus far, and whilst some of the findings should be viewed with caution, some are statistically significant and generalisable. Cardiovascular disease is the number one cause of morbidity; over 40% of the sample population were overweight whilst 60% of the sample population led sedentary lives; the incidence of smoking is higher than in the rest of the population; stress levels are also very high. The survey revealed major inconsistencies between the respondents' knowledge about illness causation and their health behaviours. It also revealed that health workers, particularly GPs are failing to provide adequate and relevant health advice. The findings from the survey on the primary health needs of the Greek Cypriot women revealed the inability of health workers to provide culturally sensitive care and highlighted the problems faced by those who speak little or no English. The knowledge of the health purchasers and providers about the needs of the Greek Cypriots varied but it was generally far from being adequate.

The study makes a number of recommendations for health policy, action and research.

Policy makers and health providers need to compile a detail profile of the health, illness and lifestyles of the Greek Cypriot community which, in North London at least, forms one of the largest minority ethnic communities. There is no doubt that the Greek Cypriot community, needs to collaborate with the health purchasers and providers in the development and implementation of health promotion campaigns which must acknowledge the importance of culture and language. Some of the difficulties faced by the Greek Cypriot community may be alleviated if more members of the community entered the caring professions particularly nursing. A model for the promotion and provision of culturally competent care is suggested. Finally, it is recommended that more research is undertaken in some of the areas identified in the study particularly on the effects of culture on the first and subsequent generations of Greek Cypriots, on sensitive health issues such as mental health, sexual health, bereavement and loss, as well as the centrality of family as a force for health and illness.

CHAPTER 1

INTRODUCTION

THE NEED TO ADDRESS THE HEALTH OF MINORITY ETHNIC GROUPS

In England and Wales, there are an estimated 3 million people of minority ethnic origins, constituting 6% of the total population. In some areas of inner cities (such as Brent, in London) this rate is as high as 45%. The rates of ill health and mortality among these ethnic minority groups differs from those of the white indigenous population, and differences exist between the ethnic groups themselves (Balarajan and Soni Raleigh 1993). The reforms in the National Health Service (NHS) following the government White Paper *'Working for Patients'* (1989a), and the NHS and Community Care Act (1990), have both highlighted the need to improve the services for people from minority ethnic groups and provided opportunities for purchasers to improve health and health care delivery systems. The health of ethnic minorities was also discussed in the Chief Medical Officer's (CMO) report *'On the State of the Public Health 1991'*, published in 1992, which pointed out that the NHS must address the particular needs of the black and ethnic minorities living in Britain, and take positive steps to eliminate discrimination. The report also pointed to the need for people working within the health service to be aware of ethnic differences in disease patterns, and considered how such differences can be met by the provision of appropriate services embracing all aspects of health care, therefore modifying approaches to take account of cultural variations. By 1995, the CMO's report for the preceding year, reports briefly on five developments which are seen as a major contribution towards addressing issues related to minority ethnic groups. These were:

1) the establishment of the NHS Ethnic Health Unit,
2) the funding of a number of projects related to the health of black and minority ethnic groups,

3) the report from the Standing Medical Advisory Committee on sickle cell, thalassaemia and other haemoglobinopathies,

4) the publication of national implementation guidance and training material on ethnic monitoring, and

5) the launch of the programme of action for ethnic minority NHS staff.

In all government publications about the health of minority ethnic groups, the analysis and other evidence which is used, is based on the ethnic groupings used by the government thus far to collect data on health, mortality and morbidity as well as major population surveys such as the decennial population census (Smaje 1995). These groupings are: White, Black Caribbean, Black African, Black other, Indian, Pakistani, Bangladeshi, Chinese, other Asian and Other. In the 1991 census, people of Greek and Cypriot origins were classified as *'white'*, since these communities were not considered large enough to warrant separate identification.

Smaje (1995) suggests that whilst there is some evidence that policy-making is beginning to move towards a wider conception of the health of minority ethnic populations, there is a lack of both knowledge and agreement about how this wider conception can be translated into practical policy initiatives. He argues that the existing knowledge of ethnic patterns in health experiences is incomplete and that there is very little known about many ethnic groups such as the Irish, Chinese, South and East Europeans, Arabs and others such as people with mixed ethnic origins. This situation may be in part due to the ambiguities about the definition of ethnicity in comparison to race (an issue which is discussed further in Chapter 2), but may also relate to the small size of the relevant populations or their invisibility in official statistics.

The Greek and Greek Cypriots living in Britain constitute one of the minority ethnic groups which has received very little attention in terms of research and service provision. In 1986, it was estimated that there were some 200,000 Cypriot born persons and descendants (Greek or Turkish origin) living in Britain (Cyprus High Commission 1986). This exceeds the Chinese population reported by the 1991

Census as 146,000 and the Bangladeshi population of 162,000 (OPCS 1992a). It could be argued that the lack of official statistical information about the Greek Cypriot community may result in inequalities at all levels. It may be the case that policy makers are making policy without any knowledge of the needs of this group. Service providers and care givers are operating on the assumption that this group's needs are no different from the indigenous population. Educators are preparing practitioners without any reference to the needs of this group. Even those who wish to research into the needs of this group are hampered by the system which does not provide sampling frames and does not make funds available as the need is neither recognised nor viewed as a priority. The few studies that have been done are small and remain unpublished in academic or professional periodicals and are therefore inaccessible to a wide audience.

Seedhouse (1986), who conducted an analysis of the ways in which the concept of health has been conceived, explained and used, concluded that people's health cannot be fully understood in isolation from what people do in their lives and that health cannot be understood in only biological terms. Dahlgren and Whitehead (1991) illustrate this by using a four layered model of health determinants surrounding the individual core made up of a person's age, sex and hereditary factors. These are firstly, individual lifestyle factors, secondly, social and community influences, thirdly, living and working conditions, and fourthly, general socioeconomic, cultural and environmental conditions. Notwithstanding the importance of biological factors, and whilst acknowledging that most research on minority ethnic groups has tended to be disease-led (HEA 1994), the opening paragraph of this chapter alluded to the fact that variations in health, mortality and morbidity between minority ethnic groups (MEG) and the white majority group, may be related to cultural variations in health beliefs and practices, as well as the existence of inequalities in all four levels of factors which determine health. More specifically, some of these inequalities may be due to ethnicism and discrimination within the NHS and British society in general.

My study of the Greek and Greek Cypriots living in two London Boroughs will adopt the perspective that a group's cultural background has an important influence on

many aspects of its peoples' lives including among others their beliefs, lifestyle behaviours and attitudes to health and illness, all of which may have important implications for health and health care (Helman 1990).

The term *'lifestyle'* is a complex one, used in many different ways. Leddy and Pepper (1989) have suggested that one's lifestyle, includes patterns of eating, exercise, drinking, coping with stress, the use of tobacco and drugs, and are the major known modifiable causes of illnesses in America today. They have argued that lifestyles are influenced by cultural expectations. Many specific diseases have been linked to peoples' lifestyles, such as smoking with lung cancer, emphysema and cardiovascular disease, alcohol abuse with cirrhosis of the liver, high fat diet with heart disease, certain sexual practices with sexually transmitted diseases, and so on. They went on to say that, the cultural factors affecting lifestyles, where they can be identified, are often difficult to quantify and are therefore less attractive to medical epidemiologists and statisticians. Nevertheless despite this difficulty in quantifying cultural factors, there is sufficient evidence available to confirm their role in the development of disease, even if this role is contributory rather than directly causative. It should also be remembered that in some cases, cultural factors may protect against ill-health; for example, heart disease in Japan is much lower than that found in Japanese living in USA especially those who adhere less to Japanese traditions (Marmot and Symes 1976). Fox and Benzeval (1995) remind us that lifestyle behaviours are influenced by health beliefs but go on to support the position put forward by Morris (1990) in that there is a need to confront the social structures in which the lifestyle behaviours are embedded. Backett and Davison (1995) have suggested that the concept of lifestyle has been central in the development of a socially based model of health in health promotion and theory, but they have warned against the use of lifestyle data without adequate reference to the social and cultural contexts in which the lifestyle behaviours are embedded and given meaning. A large part of my study (Chapter 8) will investigate a number of lifestyle behaviours as well as the knowledge of, and attitudes towards, health-risks.

Radley and Billig (1996) have suggested that when researchers speak of health beliefs they usually refer to a number of issues such as how ordinary people give lay accounts of their experiences of ill-health (Blaxter 1983, Williams 1990); how they think about avoiding disease (Pill and Stott 1982); how they define health (Blaxter 1990); or how people in different sections of society hold different views about health matters (Blair 1993, Pierret 1993). Critiquing the work of various researchers, Radley and Billig (1996) concluded that *'health beliefs'* are both ideological and dilemmatic. They are ideological because any attempts to define *'a healthy life'* involves ideological judgments. They are dilemmatic because people use health beliefs to make themselves accountable to others and to articulate for others their own position in the world. In doing so they are taking for granted a world in which, for example, caring for the sick by women appears as natural values. In this way, they argue, health beliefs are always more than health beliefs. The literature on health beliefs pays little attention to minority ethnic groups. However, some findings may be pertinent to this study such as Blaxter's (1993) evidence that health beliefs differ across age, gender and class, and they are contextual and inconsistent, sometimes contradictory and confused. Cornwell's (1984) distinction of public and private health beliefs also merits attention although Radley and Billig (1996) have criticised this distinction. Chapter 7 of this thesis is an exploration of the health beliefs of the Greek Cypriots who took part in my study.

If the aim of the National Health Service is to improve the health of the whole population and to achieve equality by narrowing the existing health gap between those who are at the top of the social strata with those at the bottom, and between the *'white majority'* and the *'ethnic minorities'* then the most important starting point must be the possession of accurate, detailed information of the population. Rawaf (1993) put forward a five step process needed in order to understand the dynamics of a population which would help in the provision of appropriate services and effective care. These are:

a) the development of a population profile,
b) an investigation into people's lifestyles,

c) an examination of the environment,

d) an analysis of the population's health problems, and

e) a critical evaluation of the utilisation of services.

This means that in a multi-cultural Britain, health service policy makers, must not only expect, but must also enable local purchasers and providers in their efforts to construct such population health profiles. However, the evidence seems to indicate that a number of fundamental problems still exist in achieving such comprehensive population profiles, such as the absence of a system which could link the information gained from the various activities in a coherent way, the lack of collaborative relationships between the variety of health providers (DoH 1994a), and the lack of staff training and resources (London Community Care Action Group 1994). As an illustration of the relative failure to implement government policy (DoH 1989a, 1990a, 1991, DoH/NHSME 1991), I refer to the case of the Enfield and Haringey Health Authority, which has consistently neglected to generate relevant health information about its largest minority ethnic group, that of the Greek Cypriots.

Although political ideology determines government policy, and to some extent it constructs and directs societal attitudes, we must not dismiss the influence that societal as well as global debates and pre-occupations may have on policy. For example, in Britain in the 1970s and early 1980s the debate around improving the health of people from minority ethnic groups was focused on multi-culturalism which sought to improve the health of minority ethnic groups primarily through the promotion of knowledge and understanding of the various cultural traditions of ethnic groups. At the World Health Organisation the concern was amongst other, the provision of a nutritional diet, clean water, adequate housing and education to the whole world's population. By the late 1980s and early 1990s the assumptions and approaches of multi-culturalism were being criticised, and the focus of the debate became that of the racist and discriminatory societal and NHS structures. By the mid 1990s a new approach was taking roots; this approach was based on evidence which indicated that social forces such as poverty, inequality and social exclusion were important health determinants. The evidence, which began to emerge in the early

1980s reflected the changing political ideology in the country which had been dominated by the right wing politics of individualism during the 1980s and up until 1997 when the Labour Party won the general election.

By the time this study was fully completed a number of important developments had taken place primarily as a result of the Labour Party winning the General Election. A number of policy documents with direct relevance to health and social welfare have been issued during the latter part of 1997 and at regular intervals since then. According to the government, these aim at '*modernising*' the National Health Service (NHS) making it more able to deliver dependable, high quality care within a framework which is based on fairness and partnership. The broader government policies claim to tackle social exclusion and inequalities. Poverty, often the cause of, and the result of both exclusion and inequality, has now been strongly linked to poor health. The new NHS reforms appear to have adopted the underpinning principles of the World Health Organisation's strategy '*Health for All*' (WHO 1985). Thus, apart from endeavouring to reduce poverty, the government appears to be determined to secure for all, the basic prerequisites for health such as good nutrition, decent housing and education, reduction of crime, and access to effective health care. In order to achieve this ambitious agenda, the government is placing much emphasis on the development of effective partnerships between itself, the health authorities, local authorities, businesses, voluntary organisations and the public.

In December 1997, the White Paper called '*The New NHS. Modern Dependable*' was published. It set out the framework through which the internal market system, put in place by the previous conservative government, is to be replaced by integrated care, based on partnership and driven by performance. Integrated care will be achieved through the development of local 'Health Improvement Programmes' (HImPs) which will be jointly agreed by all who are charged with planning or providing health and social care. In order to develop more co-ordinated services for vulnerable groups, and to facilitate an on-going joint working as a core activity, health and local authorities will be required to draw up joint investment plans (JIPs). It is envisioned

that the major force in shaping the local health services of the future, will be the Primary Care Groups (PCGs).

PCGs will yoke together General Practitioner (GP) practices and other community health professionals to develop joint strategic plans for primary and community care covering local populations of about 100,000 people. The emphasis will be on collaboration and multi-disciplinary working. Drawing on the expertise of GPs, community nurses, health visitors, health promotion professionals and others, PCGs will plan and provide services, promote the health of the local population and work in partnership with social services.

Since the publication of the NHS White Paper, the government has been busy producing consultation papers and detailed guideline documents on the mechanisms which need to be put in place so that their ambitious plans can be implemented. There has also been a White Paper on Social Care (DoH 1998b). The Green Paper *'Our Healthier Nation: A Contract for Health'* (DoH 1998b) states that good health is the foundation of good life, and that better health for the nation is central to making a better country. It acknowledges that health inequalities are widening and that social and economic issues such as poverty, unemployment and social exclusion are some of the complex causes of poor health. It reiterates the importance of health partnerships between the government, the health and local authorities, businesses and voluntary bodies. It identifies three settings for action: the school (focusing on children), the workplace (focusing on adults) and the neighbourhood (focusing on older people). There will be four priority areas to be targeted: heart disease and stroke, accidents, cancer, and mental health.

In November 1998 the report of the *'Independent Inquiry into Inequalities in Health'* (Acheson 1998) was published. It also claims to have been inspired by the work of WHO, particularly its European *'Health for All'* policy. The report acknowledges and builds on Sir Douglas Black's ground breaking report *'Inequalities in Health'* (1980). It emphasises that the roots of ill health lie in such determinants as income, education, employment, environment and lifestyle and concludes that their

recommendations for the eradication of the unacceptable inequalities in health which exist, go far beyond the remit of the Department of Health but to the whole Government. The report includes a section on ethnicity which begins with the problems surrounding the issue of definitions, but chooses a definition which focuses on cultural identity, place of origin and skin colour, which means that both white and non-white groups are included. It goes on to highlight the problem of not having accurate ethnic data and the total absence of such data for some groups. The report deals with issues around mortality, morbidity and socioeconomic status; it states that people from minority ethnic groups have higher than average rates of unemployment and that there is a clear association between material disadvantage and poor health. It also points out that classification based on occupation is inappropriate as a measure of socioeconomic status in minority ethnic people. The report recommends that the needs of minority ethnic groups are specifically considered in the development and implementation of policies aimed at reducing socioeconomic inequalities. The quality of services as well as access to services is also tackled by the report which catalogues a number of problems encountered by people from minority ethnic groups. One of the solutions which it recommends is to train health workers in *'cultural competency'*. It goes on to recommend that further development of services which are sensitive to the needs of minority ethnic people and which promote greater awareness of their health risks are needed. In addition, the report recommends that the needs of minority ethnic groups are specifically considered in needs assessment, resource allocation, health care planning and provision.

The reader of this thesis will soon discover, that even though the main aim of the study was to explore a number of health issues which were pertinent to Greek Cypriot people living in two London Boroughs, the thesis covers much of what has been highlighted above. Naturally, much of the evolving health policy is still under consultation; implementation has only just started and it is therefore too early to predict the level of success it may have. Powell (1998), in critiquing the *'new'* NHS reforms wonders how *'new'* and *'modern'* they really are. He warns that although the new proposals have no shortage of worthy aims, the mechanisms to achieve them appear to be similar to mechanisms which either failed in the past or were distrusted

only a short time ago. Whilst individual proposals may be appealing to all, the way in which they are put together may end up pleasing no one.

AIMS OF THE STUDY

This study, aims to provide some insights into the health beliefs, self-reported health status, and selected lifestyle behaviours of the Greek Cypriots living in two London Boroughs. The position taken in this study is that health professionals have very little knowledge about these important factors. I will argue that such knowledge is fundamental to both health care policy makers and providers; the arguments for this need are similar to those put forward by individuals and bodies who are concerned with the promotion of the health of other minority ethnic groups. My thesis is based on the following three major assumptions:

a. that there are variations in health beliefs, lifestyle behaviours and health status, between the Greek Cypriot population and those of the ethnic majority living in England,

b. that health professionals have little information about the health beliefs, lifestyle behaviours and health status of the Greek Cypriots and therefore little understanding of their health needs,

c. that health professionals are failing to meet the health needs of the Greek Cypriot community.

This study aims to address the following questions in relation to Greek Cypriot people living in two London Boroughs:

1. What are the health beliefs, lifestyle behaviours and health status of the Greek Cypriots?

2. How do they compare with those of the general population of England?

3. What information about the Greek Cypriots do health workers have?

4. What understanding do health workers have of the health needs of the Greek Cypriots?

5. Are health workers providing culturally competent care which matches the actual needs and expectations of the Greek Cypriots?

The questions which the study will address are focusing on problems from the real world and would be looking for explanations and understanding from more than one discipline. I will mainly be drawing from sociological, anthropological and health disciplines, as well as from the emerging theories on culture, ethnicity and health. It is important to state that although *'health related'* services in Britain, are provided by the NHS, the local authorities, the voluntary sector and the expanding private sector, this study will be firmly located within the NHS provision. Reference will be made to the other sectors where appropriate.

OVERVIEW OF THE THESIS

Following on from this introductory first chapter, chapter 2 details the research design and methodology. It discusses the rationale for the choice of the design, the ethical issues associated with the study, the sampling approaches, data collection and analysis strategies as well as the difficulties which were encountered and how they were dealt with.

Chapter 3 describes the setting of the study. It begins with a short overview of the conservative government's NHS reforms. As the study was undertaken in two London Boroughs, the chapter provides an overview of the London-wide health

issues and a more detailed picture of the population profile and health issues which relate to the two London Boroughs (Enfield and Haringey).

Chapter 4 provides some ethnohistory of the Greek Cypriot Community living in Britain. This is considered important background information needed to understand the current health status of the Greek Cypriots living in Britain. Examining the history and geography of the place of people's origins provides important insights into their culture and lifestyles, and how these may impact on their health, whilst a consideration of the migration processes helps us understand the adjustments people make in a new country and some of the associated physical and psychological problems they may suffer from.

In Chapter 5 the two dominant perspectives around the health of minority ethnic groups, those of multi-culturalism and anti-racism are presented and critiqued. The emerging perspective, which has inequality at its heart, is discussed.

Chapter 6 discusses the need for local health status profiles in the provision of appropriate, culturally sensitive and accessible health services. As this process depends on the availability of demographic, epidemiological and cultural knowledge, some of the possible reasons of the absence of such data for the Greek Cypriot community are discussed.

Chapter 7 provides an in-depth exploration of the health beliefs, lifestyle behaviours and perceived health needs of the Greek Cypriot community from three different perspectives. Some useful insights of the relationship between culture and health are presented.

Chapter 8 presents the findings of the health and lifestyles survey of the Greek Cypriots living in the London Boroughs of Enfield and Haringey. In order to establish whether or not the health status and lifestyle behaviours of this minority ethnic group differ from the majority white population, the findings are compared as far as possible

with those from the Newcastle Health and Lifestyle Survey 1991 and the Health Survey for England 1991.

Chapter 9 presents the findings of the survey of the views of health purchasers and providers in Enfield and Haringey, regarding the health needs of the Greek Cypriot Community and the provision of services. This was undertaken in order to establish the extent to which health service personnel understand the health needs of this minority ethnic group, something which - as discussed earlier in this chapter- is a pre-requisite to the provision of appropriate and culturally acceptable services and care.

Chapter 10 brings together the main findings from Chapters 7, 8 & 9, and discusses their significance in terms of current policy and practice.

Chapter 11 considers the contribution of this study and makes some recommendations for further research.

CHAPTER 2

METHODOLOGY OF THE STUDY

METHODOLOGICAL ISSUES

As the aim of this research was to investigate the health beliefs, status and lifestyle behaviours of a section of the Greek Cypriot community, issues which may influence the methodology of study needed to be identified. These are articulated into the following considerations:

a) the Greek Cypriots are a minority ethnic group (MEG);
b) the study would involve Greek Cypriots residing in two London Boroughs;
c) there is a lack of both qualitative and quantitative data regarding the health of this ethnic group;
d) there are similarities and differences in terms of health issues, between minority ethnic groups;
e) similarities may be: the importance of culture, the experiences of migration and racism and their disproportionate afflictions of health inequalities;
f) differences exist: each minority ethnic group has its own ethnohistory which plays a significant role in defining its people's identities;
g) ethnohistory, culture, the process of acculturation and the overall experiences of life in the UK, influence people's health beliefs, lifestyle behaviours and health status;
h) the context of these considerations, which is one of enormous change.

A most important requisite for any research study is a deep familiarisation with relevant issues which will both determine and underpin the study design. Issues, whether theoretical or practical in nature, are added to as time goes by, or, when their initial importance may shift. When researching an area which lies within the flux of health and social policy, the continuous reviewing of a wide ranging published academic literature, published government reports and papers, as well as locally

produced ones, become a crucial and vital activity. Hunter (1994) commenting on the NHS reforms of the early 90's stated that:

> *Never before in the history of these services have so much change and turbulence been unleashed simultaneously.*
>
> *(p16)*

Popay and Williams (1994) believe, that towards the close of the twentieth century, researching the people's health seems an ever more complex and uncertain endeavour. Despite the uncertainties, two developments are taking place: firstly, the growing importance of the role of social scientists, and secondly, the need to take seriously people's own views about their health and their health needs. Bradshaw (1994) argues that the adoption of a social model of health, commonly associated with the WHO definitions of health (1946 and 1985), necessitates that research considers not only curative medical interventions but also prevention and rehabilitation. The social model focuses on the interaction between health and social structure, thus emphasising the impact of disadvantage and inequalities. He suggests that researchers must extent their methodologies to include people's self-reports of health/illness experience that include physical, social and emotional factors. Popay and Williams (1994) support this position and point towards the limitations of the bio-medical research paradigm to deal with the health problems associated with chronic disease, AIDS, etc or to make any real impact on the growing inequalities of health.

Therefore the methodological principles adopted for this study are :

1. the need to include a variety of methods in order to illuminate the area under study,
2. the need for an extensive and on-going literature review,
3. the primary purpose of the study is to provide health insights for a minority ethnic group which has been neglected by researchers, policy makers and providers,

4. the inclusion of lay perspectives, which are accorded 'equal worth' as those of professional perspectives (Stacey 1994),
5. acknowledgement of limitations.

A number of methodological problems have been identified in the literature associated with the complex area under investigation. Macintyre (1986) states that health and illness are important variables for research but they are extremely difficult to define and measure. Health and illness definitions may vary between cultures, between historical periods, between individuals and between the same individual at different times. Probably the most difficult of all social variables for researchers is that of ethnicity (Bulmer 1986). A number of writers have criticised the construction and use of ethnic statistics on political, theoretical and practical grounds (Ahmad and Sheldon 1991, Sheldon and Parker 1992, McKenzie and Crowcroft 1994, Senior and Bhopal 1994, Smaje 1995). One of the arguments put forward is that ethnic statistics deflect attention from racism. They ignore the fact that people do not always classify themselves in the same way and that ethnic identity changes over time. Probably the most serious concern is the current conflation of ethnic groups into generic (some would argue, meaningless) categories such as *'White'*, or *'Indian'* or *'Asian'*. The most relevant of all criticisms to this study, is the fact that ethnic statistics do not provide refined data about many minority ethnic groups including the Greek Cypriots living in the UK. The limitations which the absence of such data present to this study have already been discussed in Chapter 1.

Pfeffer and Moynihan (1996) suggest that ethnicity and culture are both woolly categories. The use of *'culture'* has been heavily criticised on the grounds that it encouraged researchers to explain variations in health and disease and health service utilisation, in terms of cultural pathology. On the other hand, many have argued that understanding people's cultural backgrounds is of crucial importance, as without this understanding, the provision of appropriate and acceptable services may be questioned (Helman 1990, Leininger 1995, Kelleher 1996).

Another issue which needed to be considered prior to deciding the direction of the research design, was my own role in the study. As a Greek Cypriot person researching the Greek Cypriot community, could be seen both as advantageous and problematic. I considered the advantages to be:

⇒ my ability to speak, read and write Greek,

⇒ my possession of *'a rich fore understanding'* (Ashworth 1986), *'sensitising concepts'* (Hilton 1987) and an *'insider/emic view'* (Burgess 1984, Leininger 1991, Kauffman 1994),

⇒ a genuine interest in the health and welfare of this community (Hillier and Rahman 1996),

⇒ being someone the community could identify with, a *'trusted friend'* (Leininger (1991),

⇒ favourable access conditions and co-operation of a large number of people (Hanson 1994).

However almost each advantage could also be viewed as a disadvantage unless I made a conscious effort to deal with it. It could be argued that my *'insider view'* would sensitise me to the extent that, particularly during the interviews, I could be taking for granted information, that an *'outsider'* would not miss. My keen interest could result in becoming biased and losing my objectivity. Being a member of the community, could stop me from asking those *'naive'* questions (Kratz 1978) which could yield many useful explanations. Having easy access and co-operation may result in exploitation of the group (Burman 1996).

The starting point for dealing with this situation, is to acknowledge the potential dangers and seek ways to overcome them. Hammersley and Atkinson (1995) advise that in order to avoid over-identification and over-rapport with the population being studied, the researcher should aim to adopt a marginal position of simultaneous insider/outsider, and be intellectually poised between familiarity and strangeness. This provides some social and intellectual distance, which they call *'analytic space'*.

Leininger (1991) recommends that the researcher should keep an *'open mind'* and suspend personal beliefs, past professional and research experiences, thus eliminating biases and prejudices. Hammersley and Atkinson (1995) and Becker (1970) acknowledge that it is very difficult to suspend one's perceptions. The strategies which I adopted were: awareness, reflexivity, use of research supervisor and informal mentors. Awareness of these potential dangers from the start, enabled me to plan my procedures and strategies particularly for undertaking and analysing the interviews. Being reflexive, I paid attention to research processes (as can be seen in the *'ethics and procedures'* section of this chapter), kept copious notes and always asked *'why'*. During the various stages of the study I had the opportunity to discuss related issues with my supervisor. I also used a number of informal mentors with whom I regularly discussed my progress. During the period of this research, I also produced a number of publications which underwent informal reviewing by my mentors, whilst the publishers scrutinised them through peer-review. It is impossible for me to say that I fully succeeded in my endeavours to be objective and non-biased in both the data collection and analysis, but I hope that the above strategies would have contributed towards achieving an acceptable standard of objectivity.

RESEARCH DESIGN

The research design took into consideration the methodological issues which were discussed above. In order to address the study's research questions, it became obvious that methodological pluralism was needed. Thus, a number of different approaches were adopted which are first summarised in the table below and are then discussed in more detail.

Table 2.1: Overview of research methods

METHOD	TYPE OF SAMPLE	NUMBER	GENDER
Group/individual interviews	Club for the Cypriot elderly and disabled. (1 morning per week over 4 weeks) Greek Cypriot Womens' Club. (1 afternoon and 1 evening)	19 50	3 men 16 women All women
In-depth interviews	Members of the community in their own homes	10	3 men 7 women
London Greek Radio Phone-in programme	Members of the Greek community living in North London	11	5 men 6 women
In-depth interviews with key community informants	-Ex mayor of Haringey -Officer in charge of Cypriot community centre -Officer in charge of Elderly club -Officer in charge of Womens' centre -Officer of women's' centre -Press Officer, Cyprus High Commission	6	4 men 2 women
In-depth interviews with Greek Cypriots working in the health field	-2 General Practitioners, -1 Osteopath, -2 Link workers, -1 Alcohol Adviser, -1 Thalassaemia counsellor	7	3 men 4 women
Postal Survey of Greek Cypriots living	249 randomly selected persons living in Haringey 241 randomly selected persons living in Enfield	151	62% Female 48% male
Exploratory interviews with key health services purchasers and providers	- 1 Director of Needs Assessment, New River Health Authority (NRHA). - 1 Commissioner for health and race, NRHA - 1 Enfield Community Health Council - 1 Haringey Community Health Council - 1 Health visitor - 1 Team leader, health visiting - 1 Locality manager	7	1 man 6 women
Analysis of documents	- NRHA/Enfield Local Authority community care plans - NRHA/Haringey Local Authority community care plans - NRHA/E & H H.A. Purchasing Plans, Health Strategies		
Postal Survey to providers and purchasers	2 Purchasers (P) 2 Hospital Trusts (H.T) 2 Community Trusts (C.T)	1 P 1 H.T 2 C.T	
TOTAL SAMPLE		**256**	

Exploratory group and individual in-depth interviews

In order to explore the health beliefs, lifestyle behaviours and perceived health needs of the Greek Cypriot people living in the two North London Boroughs of Enfield and Haringey, *'small group'* and individual interviews were conducted with a number of first generation elderly people and a number of predominantly first generation women. This was done, as at the time, the intention was to include case studies of both these groups. Both my personal knowledge of the Greek Cypriot community and the literature dealing with other minority ethnic groups, indicate that first generation elderly and women encounter health difficulties which warrant concerted attention.

Following the exploratory interviews, a number of themes emerged which were explored further, verified, confirmed or modified during the in-depth individual interviews with ten men and women of different ages and generations. Four of the female and two of the male informants were of first generation, whilst three female and one male were second generation.

Both approaches provided a rich source of material. The interviews were conducted in Greek and were transcribed in English immediately after each interview. The interviews were semi-structured. A small number of areas were identified for the exploration, which was conducted in an informal way. Informants were asked to talk about their health and illness beliefs and whether they thought being Greek Cypriots affected the way they viewed health, illness, the National Health Service and the care they received from health professionals. They were also asked to talk about the state of their health and to make suggestions about the kind of health services most needed by the Greek Cypriot community.

In relation to the exploratory interviews undertaken with two groups of women, it is important to state that conducting interviews with groups of twenty-five people was not ideal and presented a methodological challenge. It was an approach taken in the knowledge that it might have failed. However, in order to gain access to large numbers of women, the management committee of the voluntary organisation of

Greek/Greek Cypriot women which was approached strongly advised that women would not attend 'interview meetings' unless they were part of another activity which featured in the organisation's programme. A large number of women were at the time attending weekly meetings on 'health matters'. The executive committee considered that the most appropriate way to involve these women in my study would be:

a. To provide sessions on nursing careers in the NHS which some women had requested in the past;

b. To introduce my study and invite those who wish to take part in a group interview after each session and;

c. To avoid tape recording the sessions.

Each of the two meetings that were organised was attended by twenty-five women all of whom agreed to take part in the group interviews. During the interviews, the women were very talkative and it was difficult at times to keep them focused. A number of factors contributed to this. Firstly, the women were familiar with their environment which provided a friendly and relaxed atmosphere. Secondly, they knew each other and were thus not inhibited from sharing personal stories. Thirdly, the preceding session which dealt with health and nursing acted as a precursor to the group interview.

On reflection, even if I were permitted to tape record these group interviews, the recordings may not have been of good quality due to the size of the group and the frequent simultaneous contributions of the participants. A more effective approach might have been to use an assistant note-taker so that I could concentration more in obtaining a better balance between the general aspects of personal stories and those that were specific to my investigation.

The radio programme

Early in 1993, the London Greek Radio (LGR) agreed to devote one of its programmes called *"Your Own Opinion"*, on the views of the Greek community about the changes which were taking place within the NHS. The programme is a weekly *'phone in'* lasting 1 hour and 30 minutes, and is interspersed with songs. In order to discourage the public from ringing with their own health problems, and asking for advice, it was decided to focus the programme on the public's views about the profound changes in the NHS which were taking place at the time, primarily as a result of the NHS and Community Care Act 1990, the changes into Trust status for service providers, the Health of the Nation Strategy (1992), the Patient Charter and so on. Unfortunately, a power cut reduced the effectiveness of this approach and it was not possible to repeat the programme. Notes from five men and six women (two women spoke in fluent English, which may indicate that they were second generation Greek Cypriots), were included with the analysis of the interviews with the Greek Cypriot public.

In-depth interviews with key community informants

As the study progressed, I sought to expand the description and verify the information I had collected, with participants with specific knowledge. Six individuals who for many years, held positions which brought them into daily contact with members of the Greek Cypriot community, were interviewed. One of them was an ex-mayor of Haringey, who was a councillor in that borough for 15 years. He had emigrated to Britain as a young adult and had spent all his working life, dealing with Greek Cypriots either through work, public office or in a voluntary capacity. He was very articulate with an extreme insight into issues of migration, socio-economic problems of the community, issues around identity and values. Furthermore his political career had given him opportunities to engage in local policy and to travel extensively. He was therefore very able to make comparisons with other minority ethnic groups as well as with the majority group. Four people who hold very senior positions in Cypriot community centres were also interviewed on the basis that they also have many years of experience in dealing with the Greek Cypriot community. The Press Officer of the Cyprus High Commission, is a very senior member of the

Cyprus government and has been based in the UK for many years. He handles all information between the Cypriots of the British diaspora and the Cyprus government. He is also responsible for linking people in Britain requiring information to the appropriate ministry of the Cyprus government.

In-depth interviews with Greek Cypriots working in the health field

Seven individuals, six of whom worked within the NHS whilst one had a private osteopathy practice, were interviewed. Many of the patients of the two GPs and the osteopath were Greek Cypriots. The two link workers worked only with Greek and Greek Cypriot patients, whilst the thalassaemia counsellor had a mixed caseload. The alcohol adviser was involved because she had recently completed a study on alcohol within the Cypriot and Turkish communities.

Postal Survey of Greek Cypriots living in Enfield and Haringey

This survey on a randomly selected sample of 490 individuals was aimed at collecting quantifiable data on a number of lifestyle behaviours and views about health and illness, of the Greek Cypriots. A large amount of biographical and demographic data were also collected. The Newcastle Health and Lifestyle Survey 1991 (Harrington et al 1993) questionnaire was used as a valid and reliable tool which was extensively piloted and successfully used; this was modified slightly to include all the issues which were identified during the interviews with members of the Greek Cypriot community. For example, questions were included which dealt specifically with Greek food. Other examples included the use of private medicine, the use of A&E departments and whether or not the respondents involved themselves in any voluntary activities. The questionnaire was piloted to check that it remained valid even though it was slightly modified. The data from this survey were analysed using the Statistical Package for Social Scientists (SPSS) for Windows, version 6.

Exploratory interviews with key health services purchasers and providers

In order to investigate the understanding of issues around the needs of the Greek Cypriot community, as expressed by its members and as required by the government,

a small number of semi-structured interviews with key individuals from the purchasers and providers of health services were conducted.

Analysis of documents

A number of key policy documents which were produced for 1992-1996 were analysed. The analysis focused on whether the documents contained any specific reference to the health status and needs, of the Greek Cypriots residing in the two boroughs. The underlying assumption for this analysis was that in order to address the health needs/problems of this (or any other) minority ethnic group some attempt would need to be made to establish a population profile, by examining their lifestyles, and by having data which provide patterns of service utilisation. It would not be unreasonable to expect to find references of such information in documents such as Sector Profiles, Health Strategies, Health and Race Policies, Annual Public Health Reports, Community Care Plans, Business Plans, Purchasing Plans, Patient's Charter Reports and so on.

Postal Survey to providers and purchasers

Information gained from the interviews with key purchasers and providers, as well as from the documentary analysis, was used to develop the questionnaire which was sent to the chief executives of purchasers and providers of health services, in Enfield and Haringey. This survey was perceived as a useful activity as it aimed to give the respondents an opportunity to provide examples of practices or policies which were referred to in their documents or by their staff, whilst adding new details to their plans for creating a more culturally competent service for the Greek Cypriot community.

RATIONALE FOR THE CHOSEN RESEARCH DESIGN

The questions which I wanted to investigate did not fit neatly in either of the two dominant paradigms (the positivist / quantitative and the interpretative / qualitative). In any case, the usefulness of adhering to either one or other of the two paradigms in social research has been questioned by many researchers (Titchen 1993, Denzin

1979, Carr and Kemmis 1986, Popay and Williams 1994). Bryman (1988) argues that the rather partisan either / or tenor of debate about quantitative and qualitative research may appear somewhat bizarre to an outsider, for whom the obvious way forward is likely to be a fusion of the two approaches so that their respective strengths might be reaped. Bryman has suggested the following ways in which using a plurality of methods (known also as triangulation), can be useful:

- Qualitative and quantitative data can be used to check on the accuracy of the conclusion reached on the basis of each.
- Qualitative research can be used to produce hypotheses which can then be checked using quantitative methods.
- The two approaches can be used together so that a more complete picture is produced.
- Qualitative research may be used to illuminate why certain variables are statistically correlated.

Peckham (1996) also argues that in the health field there is a need for a fresh approach particularly as advances relevant to health are being made across a broad range of biological, physical, and social sciences with blurring of conventional subject boundaries, the formation of interspecialty links, and the emergence of new areas of research. These invariably require a pluralist research approach with diverse methods and techniques.

Although I concur with Cohen and Manion (1985) who view the positivistic nature of inquiry and the interpretative, ethnophenomenological one, as two complementary perspectives, and I am aware that the use of a combined methodology is generally thought to produce more valid and reliable results than the use of a single method (Blaikie 1988, Burgess 1984), I am also aware that there is no evidence to support this view (Sarantakos 1993). Lamnek (1988) warns that the use of triangulation (combined methods) might be associated with serious methodological problems such as:

- difficulties with replication,
- can be used as a way of legitimising personal views and interests,
- not more valuable than a single-method approach which can be more suitable, useful and meaningful to answer certain questions.

Leininger (1991) also opposes the use of triangulation. She affirms that one can use qualitative and quantitative studies sequentially but not simultaneously. She goes on to say that:

> *'...one can mix methods within a paradigm, but not mix methods of different paradigms as it violates the purposes and integrity of each paradigm'.*
>
> (p109)

Notwithstanding the possible methodological pitfalls and criticisms, in balance, the evidence seems to suggests that the use of multiple methods and paradigms, is a pragmatic approach to investigating complex problems.

SELECTING AND CALCULATING THE SAMPLE SIZE

a) Qualitative studies: The Greek community's perspective

The principles of adequacy and appropriateness were applied when selecting the samples. Morse (1991) argues that in qualitative studies, sampling is a process that goes on continually throughout the concurrent data collection and analysis phase and that the selection of informants is critical to the ultimate quality of the research. Adequacy refers to the representativeness of the sample which can be achieved by the sufficiency and quality of the data obtained. To ensure adequacy, one must assess the relevance, completeness and amount of information obtained. Appropriateness refers to the selection of informants who are best able to meet the informational needs of the study, in that the are willing to share with the researcher and able to reflect on their experiences. Morse has identified four types of samples commonly used in

qualitative studies: the purposeful, the nominated or snowball, the volunteer, and the sample which consists of the total population.

In this study, both the purposeful and snowball sampling techniques were used. I purposefully selected to interview the members of the club for the elderly and disabled and those from the women's' club because both the limited literature about the Greek Cypriot community and that of other minority ethnic groups as well as my personal membership of this community clearly indicated the need for more information about these two most vulnerable groups. Some of the individuals whom I selected did recommend that I should speak to their friends or associates whom they considered to have either positive or negative experiences and stories to tell. This introduction proved to be very beneficial, because as Morse asserts, this technique has the advantage of *'trust'*, as the researcher enters a new field with a recommendation from a previous informer.

As the study progressed, I sought to expand the description and verify the information I had collected, with participants with specific knowledge, as discussed in the design section of this chapter; this triangulation was used to confirm appropriateness and as will be argued in the next section, it added to the credibility, consistency, neutrality and transferability of the data. To test for adequacy, Morse recommends that the research asks *"was saturation achieved and does the theory make sense?"* (p135). Saturation is achieved when the researcher stops hearing anything new. Thus completeness is achieved by the amount of information rather than the number of cases. This is a subjective process, and as the researcher I never felt totally confident about when to stop. I was privileged to have access to a vast number of informants and was tempted to go on listening to people's stories.

The purchasers' and providers' perspectives

The sampling approach for this part of the study was mainly a purposeful one. I chose to interview individuals who occupied key positions as either purchasers or providers of services; I also sought the views of the two community health councils in the location of the study (this represents the total population).

b) Quantitative studies: The lifestyle survey

Schalk Thomas (1990) has stated that sample size depends on a number of factors, and therefore it should be calculated for each unique problem. Sarantakos (1993) also suggests that although *'correct'* sample size is derived from statistical operations and procedures, in many cases estimates are based on different criteria and on factors associated with the type of population, the type of methodology employed, the availability of time and resources, the aim of the research, the type of instruments used, the accuracy required and the capacity of the research team. It must be stressed that large samples do not always guarantee a higher degree of precision, validity, or, in general, success in a research study. Probability sampling procedures are employed, the sample size is expected to be large in order that claims of representativeness can be made. The aim is to arrive at a sample size with an *'acceptable'* sampling error, which is related to the standard error (S.E). The lower the sampling error the better. The larger the sample, the smaller the S.E but increasing the sample size has increasingly smaller effects on the S.E reduction (ie the decreases in the S.E are not proportionate to the increases in sample size).

There are several methods one can use to calculate the size of the sample depending on whether the estimation is directed towards means or proportions. In the former, the investigators are interested to ascertain trends and average scores in the area of study. In the latter, which is the case with my study, researchers endeavour to estimate the proportion of people acting in a certain way.

One popular method which is employed to calculate sample size for proportion is the following formula put forward by Foddy (1988):

$$\text{Size} = \frac{pqZ^2}{E^2}$$

p= proportion possessing the attribute being measured (an estimate based on existing knowledge)

q= proportion not possessing the attribute being measured; derived by subtracting p from 100 ie if p=80, q=20

Z= the value corresponding to the confidence interval chosen for the study (e.g. 95% or 99%)

If we are content with 95% probability (usually used for smaller samples) the value of Z=1.96

E= the maximum deviation from the true proportions that can be tolerated in a study. A value of 5 is an acceptable deviation from the true population percentages.

Calder (1979) states that the value of **p x q** varies only slightly between p = 0.2 (20%) and p = 0.8 (80%). As can be illustrated from the example below, the 'worst possible' situation is when p = 0.5 (50%) and q = 0.5 (50%).

p	0.1	0.2	0.3	0.4	0.5	0.6	0.7	0.8	0.9
q	0.9	0.8	0.7	0.6	0.5	0.4	0.3	0.2	0.1
p x q	0.09	0.16	0.21	0.24	0.25	0.24	0.21	0.16	0.09

For this study, the 'worst possible' situation would have yielded a sample size of 384.

$$\text{Size} = \frac{50 \times 50 \times 1.96^2}{5^2} = 384$$

However, baring in mind the previous references made to Sarantakos's observations as well as my personal knowledge of the Greek Cypriot community, I chose p = 80 and q = 20. Thus, the sample size was calculated as:

$$\text{Size} = \frac{80 \times 20 \times 1.96^2}{5^2} = 245$$

I estimated a 50% response rate therefore the above figure (245) was doubled (490). Questionnaires were therefore sent to 490 people.

On reflection, given the lack of published evidence on this group, perhaps a more objective and balanced calculation would have been achieved if the middle range of p and q values were adopted i.e. p = 0.65 (65%) and q = 0.35 (35%). This would have yielded a sample size of:

$$\text{Size} = \frac{65 \times 35 \times 1.96^2}{5^2} = 349$$

The purchaser/provider survey

All chief executives of purchaser and provider establishments were surveyed.

ANALYSIS, VALIDITY AND RELIABILITY

a) The Qualitative phase

Sarantakos (1993) characterises qualitative analysis as a pluralist procedure as a result of the development of many new methods which have enriched qualitative research. Despite the diversity, he argues that researchers generally agree that qualitative analysis is a cyclical continuous process that goes through data reduction, data organisation and data interpretation. Such analysis takes place before, during and after data collection and makes use of constant comparison and saturation, two of the principles of the grounded theory approach. This is the approach which I adopted during the qualitative phase of this research study; but before I describe the details, I will look briefly at the concepts of validity and reliability as they relate to the qualitative phase.

Guba and Lincoln (1981) have argued that the four basic concerns related to research rigour, namely, truth value, applicability, consistency and neutrality, are just as relevant to the naturalistic enquirer (qualitative researcher), as they are to the

scientific one (quantitative researcher); however, they have maintained that the methods which are used by the scientific paradigm are not appropriate to the naturalistic paradigm and have therefore proposed four alternative methods. These are credibility for truth value (as opposed to internal validity), fittingness for applicability (as opposed to external validity/generalisability), auditability for consistency (as opposed to reliability) and confirmability for neutrality (as opposed to objectivity). In their view, qualitative researchers should be more concerned with methodological excellence and accuracy rather than with validity; they should be concerned with transferability rather than generalisability and that in an ever changing world, dependability is the closest one gets to reliability. They finally suggest that confirmability would achieve more neutrality, as confirming the data, shifts the evaluation from the researcher, who was the centre of objectivity in the scientific paradigm, to the data themselves. Whilst there are still many arguments about the merits and demerits of qualitative research and its validity, many commentators have accepted the position of Guba and Lincoln.

Analysis of the data, as mentioned above, occurred before, during, and after data collection. I used the three stages recommended by Sarantakos: data reduction, data organisation and data interpretation. After each interview session, I transcribed the information, making additional field notes such as date, time, venue, numbers, age and gender of participants, any peculiar personal or situation characteristics, events associated with the interview, and so on. I read the transcripts several times, noting in the margins the emerging descriptors, issues and concerns. These were checked out in the subsequent interviews, thus establishing credibility through structural corroboration. Eisner (1976, 1981) suggested that structural corroboration is when pieces of evidence validate each other, the story holds up, the pieces fit, they make sense and the facts are consistent. House (1980) also points out that validity is provided by cross-checking different data sources and by testing perceptions against those of participants. Denzin (1989) refers to triangulation as a means of achieving credibility, fittingness and auditability. Webb and others (1966) also conclude that triangulation can achieve these tests of rigour; once a proposition has been confirmed by two or more measures the uncertainty of its interpretation is greatly reduced.

Emerging categories and themes from the group interviews were explored further during the in-depth individual interviews and were checked out with the key community informants as well as with the Greek Cypriot health professionals who took part in the study. This approach either confirmed or rejected the propositions inherent in the themes thus achieving the neutrality criterion for rigor.

I stopped the interviews with members of the Greek Cypriot community when the emerged themes were saturated. These interviews provided rich descriptors and explanations around the area of investigation. They also helped me choose the tools which I needed to use for the surveys and helped me decide how these should be modified to address more specifically the intended users.

The same approach was used when analysing the purchaser and provider interviews. In terms of the qualitative survey of the purchaser and provider views a simple collation of the responses was done.

b) The quantitative phase

The data from the health and lifestyle survey were analysed using the Statistical Package for Social Scientists (SPSS) for Windows, version 6. Data for a total of 361 variables were entered into the computer. Descriptive and inferential statistical analyses were performed. Frequencies, mean and spread of distribution were calculated. The Pearson Chi-square probability measure was used in order to test for significance. Due to the relative small sample in the study (151), the cut off point was assigned as $p=<0.05$. Numerous hypotheses were tested using bi-variate cross tabulations in order to discover associations. The Phi coefficient and the Cramer's V values were used depending on the size of the cross tabulation tables. Elaboration was performed to establish whether or not relationships persisted with subgroups of the sample.

c) Documentary analysis

Relevant documents were identified and obtained during 1992-1996. A three level analysis was performed: Level 1 involved the location of general information which

directly or indirectly related to the Greek Cypriot community, for example national or local demographic statistics. Level 2 involved the identification of evidence which referred to the specific needs of the Greek Cypriot community, such as specific health issues related to the Greek Cypriot elderly. At the third level of analysis evidence which may have indicated that this particular community would feature in future needs assessment activities, community and purchasing plans and so on was searched for.

ETHICAL CONSIDERATIONS AND DETAILS OF PROCEDURES

This section combines a discussion on the ethical dimensions of the study, with details of the procedures which were used. Any research, but particularly research that involves people, has to address a number of ethical issues; in doing so the researcher ensures that no harm comes to those who participate in the research study and that the work enhances the good name of the institution and the profession under the auspices of which the work is carried out. Careful consideration of the ethics of doing research would also protect the researcher too. A number of national, European and International guidelines and declarations have been made regarding research which involves people such as *'The Declaration of Helsinki of the World Medical Association (1989)'*, and the *'National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (1978)'*. The principles of this influential report also known as the *'Belmont Report'* will be used to discuss the ethical consideration of my research.

The principle of Beneficence

Polit and Hungler (1993) identify this as one of the most fundamental ethical principles and one which contains three important dimensions: freedom from harm, freedom from exploitation and risk/benefit ratio. In my study, participants were not exposed to anything which might have harmed them physically. However, I was very conscious that my questioning during interviews could result in emotional distress, such as for example when I was asking participants to tell me about any illness they may have suffered and the possible cause of their health problem. Such intrusion into

someone's personal health requires sensitive handling and a certain level of confidence that the interviewer could deal with possible questions or emotional responses.

Freedom from exploitation means that any information gained from the study will not be used against the participants in any way. This consideration is particularly relevant to vulnerable people who are normally defined as children, mentally or emotionally disabled people, physically disabled people, institutionalised people and pregnant women. My participants were all adults some of whom belonged to all those adult categories. All the subjects of my study were informed either in writing or verbally that the research was part of my PhD studies. It may be argued that this is a form of exploitation as it may appear that the immediate beneficiary of the study was the researcher. However, and in reference to the risk/benefit ratio, I perceived that the Greek Cypriot community would also gain from the research, as I intended to act on the findings, either during the study or at the end. For example, in 1994, following a number of interviews, I became aware that Greek and Greek Cypriot women in Enfield had nowhere to go for peer support and advice on health, social, welfare and education issues, which did not warrant the use of a very complex and over-stretched professional/statutory system. As a result of this observation and recommendation by the participants in my study, I, with the help of the Borough's Cypriot outreach worker, founded the ***'Greek and Greek Cypriot Women of Enfield'***, a very successful and growing voluntary organisation.

The principle of Respect for Human Dignity

This principle includes the right to self-determination, the right to full disclosure, and the right of informed consent.

A person's right to self-determination means that the person decides voluntarily and without any coercion to be involved with the study and to terminate his/her involvement at any stage without incurring any penalties. During my exploratory fieldwork, permission to interview groups (such as the elderly and the women) was first sought from those responsible for running/co-ordinating the groups. Before

permission was given to enter the groups, the co-ordinators explained to the members, (in my absence), the purpose of the research, who was doing it and what input was required from them. The co-ordinator of the women's group explained that permission was also required by the management committee. In all cases, permission in principle was granted. On meeting the groups, I also explained the purpose of the study, what I was proposing to do and how, and asked them if they agreed. I emphasised, that if anyone did not wish to take part they were quite within their rights to do so and that they should neither feel guilty or bad about it. In respect of the other individuals whom I interviewed, they all volunteered and expressed their pleasure to be involved in my research. The postal questionnaires on the other hand, were sent to a random sample whose names and addresses were obtained from the electoral register. None were followed up by a reminder letter as I chose not to mark them in any. There were two main reasons for this; firstly, the questionnaire was very long and contained some extremely personal information such as levels of health, healthy and unhealthy behaviours including questions on sexual practices as well as income. In my informed opinion, Greek Cypriots are usually suspicious about the motives of anyone who asks them to divulge information particularly on income and sexuality, both topics being regarded as very private. Therefore, in order to increase the response rate and the level of truthfulness of the responses, I needed to convince the subjects that there would be no way for me to assign a response to a person. Being a Greek Cypriot, as I explained earlier, was an advantage, although in this case I was extra cautious as some of the respondents would inevitably be known to me. Having any form of an identifier on the questionnaire may have put off some of the sceptical subjects from returning their questionnaire. The second and less important reason for not pursuing the non-responders was due to financial constraints. As I explained earlier, the study was totally self-funded and the lengthy postal questionnaire with accompanying letters in Greek and English was very costly. This omission may have contributed in the lower than expected response rate, although it was not the only one. A few people returned their uncompleted questionnaire commenting it was too long and too personal.

The right to full disclosure means that the researcher has fully described the nature of the study, the subjects' right to refuse participation, the researcher's responsibilities, and the likely benefits that would be incurred. All these have already been discusses with the exception of the researcher's responsibilities which I will discuss further down. Informed consent is based on these elements; apart from giving adequate information about the research to potential subjects, the researcher has the responsibility to ensure that the information is given in a way that it is properly understood. Hughes and Gilbert Foster (1994) argue that information should be simply worded. It should never be assumed that potential subjects will know what medical terms or professional jargon mean, however common they may be to the researcher. Moreover, a large proportion of the population has a low reading age. They suggest that written information should be pitched at 'tabloid' press level and there are recognised methods for measuring readability such as the Flesch Formula and the Gunning's Fog Formula which are also available on commonly used computer software programmes. These scales range from *'very difficult'* (0-30), *'difficult'* (31-50), *'fairly difficult'* (51-60), *'standard'* (61-70), *'fairly easy'* (71-80), *'easy'* (81-90) and *'very easy'* (91-100). The readability score for the letters which I sent out, both in English and Greek was 61.56, on the Flesch scale, which is *'standard'*.

Readability testing was not performed on the health and lifestyle questionnaire. It was assumed that the Newcastle team that had originally constructed and validated the questionnaire used in this study would have tested it for its readability score, although this was not reported. Because my intention was to use it in its original validated format, with only minor amendments to reflect the context and sample, I did not consider it necessary to undertake readability testing. Ideally however, the readability index of any tool being used should be known and not assumed. On reflection, this omission may have contributed in the low response which was achieved for the health and lifestyle survey.

Written consent was not sought from any of the subjects; as explained in the previous paragraph, verbal explanation was given and permission was asked for during the

interviews. Written consent is not normally asked for from anonymous postal questionnaires; the fact that people return them is taken as a form of consent.

The principle of Justice

This principle includes the subject's right to fair treatment and their right to privacy. Fair treatment does not start and end during participation but also applies before and after participation. The researcher must ensure fair and non-discriminatory selection of subjects base on the requirements of the research and not on the convenience, gullibility or compromised position of certain individuals. Earlier I discussed the importance of a non-prejudicial treatment of people who decline to participate or decide to withdraw from the study. During my field work I tried to adhere to a semi-structured interview schedule and a flexible set of ground rules I had set for myself, for two reasons: firstly because I wanted to collect similar information from each group of subjects, and secondly because in a naturalistic setting (often in subjects' own homes) , it is extremely difficult to keep focused and in control of the interview process. Inevitably, interviews were interrupted by telephone bells, door bells, de-tours and stories about various topics, cups of coffee and cakes and so on. The interviewee can easily take over, either because they want you to know X or because they do not want to discuss the Y which they want to avoid.

The right to privacy means being courteous and respectful when people allow you into their homes or their groups, or when key informants give time for an interview. All subjects have the right to expect that the researcher will not divulge the information to anybody or in any form, which would be linked to a particular person. In order to ensure anonymity and confidentiality, I stored all my records and completed questionnaires in locked cupboards. Naturally, for a study of this type when only one researcher is involved this is relatively easy to organise and maintain.

DIFFICULTIES ENCOUNTERED AND THE LIMITATIONS OF THE STUDY

A number of problems were encountered during the study, which have limited the investigation. These will be highlighted throughout the thesis but are reflected upon in this section.

The lack of demographic, epidemiological and cultural data

The decennial population census, has never included a *'Greek Cypriot'* ethnic group category; as a result, there are no accurate figures about the number of Greek Cypriots living in Britain. This presented a problem in terms of obtaining a random sample for the health and lifestyle survey (Chapter 8). I overcame this by obtaining the listings of a political party, which were prepared through a specially designed computer programme which identified Greek sounding names. I was able to check the accuracy of the lists by, a) going through the lists reading the names (which I could do because I am a Greek Cypriot born and educated person) and b) by sampling the electoral registers and comparing the two lists, which assured me that names were not left out. However, I was not totally able to exclude women who were not Greek Cypriots but who were married to one, although, where the first names were available, I was able to exclude those whose first name was definitely not Greek eg Sharon, Karen, etc. However, certain names such as Maria or Helen are not exclusively used by Greeks. Another problem, was due to the fact that Greek and Greek Cypriots, have similar names and therefore I could not be certain that the sample did not include some mainland Greeks, although I have argued that both groups share the same problems.

The problems with ethnic monitoring

When the study commenced, ethnic monitoring did not exist in the NHS. Since April 1995, this has applied to in-patients only; however, the government has recommended that the census ethnic categories be used which means that health authorities are not obliged to collect data on the Greek Cypriots, although some may decide to do so. Had such information existed during this study, it would have provided an invaluable source and would have added to the validity of this study.

Lack of research on the health of this group

As I have already stated, the Greek Cypriot community has received very little attention from social and health scientists. Even in Cyprus, sociological and health studies are sparse. This study was starved from findings and analyses from other related studies which could have offered either comparisons or illumination to the analysis of my findings.

Age, gender and generation bias

As I originally planned to construct a case study around the older adults and one around women, I naturally targeted those groups during my exploratory interviews. Naturally, older persons tended to be first generation immigrants. The initial design proved to be over-ambitious and neither time nor resources allowed me to pursue the case study intentions. Therefore, caution needs to be applied to the analysis of the interviews.

In the case of the health and lifestyle survey, the selected random sample included more women than men (278:212). This may be a reflection of the Greek Cypriot population living in Enfield and Haringey. The actual response rate favoured women (62%). In terms of age, only 31% of the respondents were over 55 years old, although the majority of the respondents (56%) were of first generation. Ideally, I would have liked to compare the lifestyles of the first generation Greek Cypriots with subsequent generations, but this was not possible due to the unequal number of first and second generation respondents.

Low response rate for the health and lifestyles survey

The response rate for the lifestyles survey was lower than anticipated. I assumed that my fellow country people would be very willing to participate in this study for two reasons: a) because nobody had asked them before to express their views on these topics, the findings of which would -in theory- help the community, and b) to help me -a Greek Cypriot- with my studies. These beliefs overrode the fact that the questionnaire was too long, and the advice which I was given, which was to shorten it. What I was sure, was that the questionnaire contained some very personal

questions which individuals would not answer unless the replies were totally anonymous even to me. For this reason, and also due to financial constraints, I did not mark the questionnaires and was therefore unable to do a follow up, although I did spend some time finding some telephone numbers in order to telephone as many people who had been sent questionnaires, as possible. This was unsuccessful because a) it was very time consuming, b) many names were not listed, c) some people had moved on. However, the only consensus which exists in the literature about response rates for such surveys, is that the bigger the better. A 33.2% response rate, enabled me to undertake some useful and statistically significant analyses; had the response been larger, further analyses would have been possible. The collation of data using other research methods, helped to compensate for this limitation.

The use of a small sample of purchasers and providers

In trying to compare perceptions of health need between the Greek Cypriot community and the purchasers and providers and to match this to the actual provision of services, I interviewed a small number of people using the face to face and questionnaire methods. I involved those whom I considered to be relevant. The questionnaires which were sent to Chief Executives were not completed by them but by delegated officers. My definition of *'relevant'* could be questioned; the appropriateness of the delegated officers (particularly one of them) could also be questioned. Retrospectively, it would have been more desirable, had I adopted a collaborative approach, through the use of meetings with as many of them as possible to explain the purposes of my research and by seeking their advice as to the most efficient way to collect relevant data, thus using more democratic criteria to the selection and involvement of informants. However, I cannot assume that this co-operation would have indeed been forthcoming, given the turmoil of the NHS reforms at the time.

SUMMARY

This chapter examined the methodological issues and principles which influenced and guided the research design. It detailed the selection of samples, the development and

use of data collection and analysis methods and tools, and it addressed some of the related ethical issues as well as the difficulties which were encountered, noting the limitations these imposed on the study.

The next chapter gives an overview of the NHS reforms of the 1980s and early 1990s, and considers their impact on the health of Londoners. Finally it looks at the specific health picture of two London Boroughs, the setting of this study.

CHAPTER 3

THE SETTING OF THE STUDY

BRIEF COMMENT ON THE NHS REFORMS OF THE 1980S AND EARLY 1990S

The NHS and Community Care Act 1990, profoundly altered the way the NHS is organised and managed. Local authorities took a clear lead in arranging long term care in the community for some of society's most vulnerable members, the old, the mentally ill and those with special needs including learning disabilities. Under the NHS and Community Care Act 1990, health and local authorities were urged to assess the care needs of populations taking into account factors such as age distribution, problems associated with living in the inner city, the special needs of ethnic minority communities and the number of homeless people. As will become evident in Chapter 6, both sectors are still struggling to satisfactorily undertake this enormous task.

As a result of the NHS reforms (DoH 1989a,b), Health Authorities ceased to manage hospital and community services, instead they became purchasers of health care. Providers of health care may be hospital and community NHS Trusts, independent non-NHS providers and other independent practitioners such as family doctors, dentists and voluntary organisations. GP fundholders also became purchasers. The reforms, created and put in place the mechanisms for an internal market. In addition, advances in information and health care technology are allowing a considerable proportion of the work that currently takes place in hospital out-patient departments and other acute hospital settings to shift into primary and community based settings.

However, Gladstone (1992) argues that these reforms were put into place not only as an antidote to what right-wing politicians regarded as inefficient state health care bureaucracies, but also as a way of curtailing the power of the health care professions. Goodwin (1996) along with others, comments that the creation of the internal market, which separated the National Health Service (NHS) into purchasers

and providers, was the government's response to a perceived need to improve efficiency and create value for money through a process of devolved responsibility, greater competition and enhanced consumerism. Long (1994) adds that the introduction of a market system, forced professionals to compete against each other, whilst Hunter (1994) asserts that the changes were expressly aimed at disturbing the chemistry of the NHS, particularly, at challenging some of the professional, managerial and organisational routines and standards which persisted over the years. The ideas which underpinned the reforms, although prolifically articulated and vehemently supported by right-wing economists and politicians, were extremely contentious at the time. Commentators such as Hudson (1992), and Le Grant and Bartlett (1993), expressed the view that although there may be potential benefits in employing market forces in this sector, these tended to be asserted rather than demonstrated.

A BRIEF OVERVIEW OF LONDON-WIDE HEALTH ISSUES

At this point, it is worth examining briefly some London wide health related issues as these have a direct influence on the people living in the two London boroughs (Enfield and Haringey) in which this study is located. Health,- in the context of this thesis - is viewed as a complex state, the existence or absence of which is dependent on a wide range of social and biological factors; Whitehead (1992) refers to the importance of having adequate income, safe and affordable housing, safe and satisfying employment, and an environment which promotes healthy personal lifestyles. Edwards and Flatley (1996) in their report *'The Capital Divided'* state that according to the Department of Environment's Index of Local Conditions -which looks at the degree, the extent and the intensity of deprivation-, the capital's wards are among the most highly deprived in the country. Incomes in London are more polarised than in the rest of the country. In 1995, 22% of women employees and 16% of men earned less than £4.26 per hour. The proportion of people from non white ethnic origins earning this amount was 33%. Out of London's 6.7 million population, just below 1 million were in receipt of Income Support in 1994. A long term trend in London has been loss of jobs (Oppenheim and Harker 1996). According to the 1991

Census (OPCS 1992) unemployment stood at 15% in Greater London and more than 24% in Inner London; the rates of unemployment among people in non white ethnic groups were 2 to 3 times higher than those of people in white ethnic groups. There is now plenty of evidence to show a strong association between low income and poor health (Benzeval and Webb 1995). Wilkinson (1996) has added another dimension to the link between poverty and poor health. He argues that the key determinant of health in developed countries is not only poverty *per se* but the extent of income inequalities between citizens, a situation which he calls *'relative deprivation'*. He suggests that the direct physical effects of relative deprivation are less important than the psychosocial consequences in terms of stress, self-esteem and social cohesion. Thus, it is the *'distribution'* of income, the *'degree of inequality'*, and the *'level of solidarity'* of a nation that determines its health.

With respect to housing, the 1991 Census also showed that rates of owner occupation in Inner London were the lowest in the country at 39% as compared with 69% for the rest of England. Edwards and Flatley (1996) report that rented tenures in all three sectors (local authority, housing association, private sector) have increased substantially in recent years. Around three quarters of a million London tenants receive Housing benefit. In 1993/94 London local authorities received 73,000 applications from homeless people.

According to Edwards and Flatley (1996) another important factor which has a negative influence on people's health and well-being is the presence of crime. In London, during 1981 and 1993, there was a reported increase of over 130% in violent crime. Certain black and ethnic minority groups were over represented in groups that are more likely to be victims of crime. London as a whole has amongst the highest rates of serious crime in the country; it also has one of the highest rates of reported drug misuse.

Thus, when considering the determinants of health, such as those put forward by Dahlgren and Whitehead (1991), as well as those of Wilkinson (1996), and the thesis working definition of health (Whitehead 1992), many people living in London are

likely to experience a significant set of factors which impact negatively on their health. Edwards and Flatley (1996) report that in London there are wide variations in mortality rates at both borough and ward level. The mortality rates of young and middle aged men in London is 20-30% higher than the national rate. Mortality among the under fours and in women between 15-45 are noticeably higher than the national average. The infant mortality rates within the most deprived Inner London boroughs are up to twice as high as within some Outer London boroughs. Limiting long-term illness in certain Inner London boroughs is 23% greater than expected, compared with 25% below the expected level in the least deprived areas. Benzeval et al (1995) and Eames et al (1993) have suggested that people who live in the most disadvantaged circumstances have more illness, disability and shorter lives than those who are most affluent. They have also suggested that people in unskilled occupations and their children are twice as likely to die prematurely than professionals. Edwards and Flatley (1996) conclude that, despite the existence of much wealth and privilege to be found in some parts of London, overall, the health of Londoners is affected by the fact that there are more young people, a more transient population, and areas with high level of material deprivation.

Clearly the 1991 Census and subsequent studies have shown that there is a growing divide between the capital's most and least deprived areas. Benzeval et al's (1992) study of the health status of Londoners allocated three different categories to District Health Authorities based on mortality and morbidity statistics: inner deprived, urban and high status. Enfield and Haringey Health Authority consists of a mixture of high status (Enfield) and inner deprived (Haringey). Bearing in mind these facts, O'Keefe and Newbury (1993) suggest that the starting point for any re-organization of health services should be a thorough understanding of the health needs of the population, something which is very difficult to achieve in the absence of a unified information function for the capital. They cited three major reports, the King's Fund report *London Health Care 2010* (KF2010) (1992), the *Report of the Inquiry into London's Health Service, Medical Education and Research* (Tomlinson 1992), and *Making London Better* (DoH 1993), which they call *'damage limitation exercises'* (p57), none of which fully addressed the issues which clearly impact on the health of

Londoners, and which in their view, point towards the need for a public health policy for London. Although the KF2010 suggested that London must address the problems relating to deprivation and a decaying urban fabric, it in no way spelled out a policy which would do this. Similarly, whilst the Tomlinson report identifies the particular health needs in London, it recommends only the development and rationalisation of health services as a policy to meet the needs. The government's response to the Tomlinson's report was *'Making London Better'* in which it set out its strategy for improving the health of Londoners. This spelt out the need for action to develop more accessible local health services particularly primary and community health services, the need to achieve a better-balanced hospital service and to rationalise the specialist services whilst supporting high quality medical education and research. O'Keefe and Newbury (1993) comment that the recommendations in the three reports shifted much responsibility for health service provision onto general practice. This is, in their view, problematic mainly because none of the reports addressed the limitations of the independent contractor status of the GPs; before any such major shift should happen, issues of employment, accountability, ability to deal with population needs assessment and other matters which normally were performed by the FHSAs and HAs would need to be dealt with. The same commentators raise two other important objections: firstly, the neglect of a community orientated approach which would enhance the status of the grassroots community health services staff and adopt the principle of partnership between users of services and health workers. This would provide a good understanding of the neighbourhood thus providing the framework for a more efficient, effective and acceptable local health provision. The second objection, is the failure to recognise, that bearing in mind the unique health problems of London, the existence of a very suitable framework, that of the World Health Organisation Health for All (WHO 1992) could be used to underpin a London-wide public health policy.

O'Keefe and Newbury (1993) point out that despite the levels of deprivation and health variations which do exist in London, the capital city is a European centre for health innovation and an international centre of excellence for health care. Policy makers should stop viewing London's health within only two possible scenarios: the

bad one, which includes an acute sector in continuing economic difficulties which continues to drain resources from the primary and community sector, and the good one, which sees a transfer of funds from the acute to the primary sector. Neither takes into consideration the scope for European or global catchment areas for which London would be well placed to be a provider. To achieve this, as well as an efficient health provision for Londoners, there is a need for a dedicated London-wide information system.

OVERVIEW OF HEALTH ISSUES IN ENFIELD AND HARINGEY

Having sketched out a health picture for London in the late 1980's and early 1990's, I now return to the specific London boroughs within which this study is located. In 1992, when this study began health services for the residents of these two boroughs were planned by the Enfield and Haringey Family Health Services Authority (FHSA), the Enfield Health Authority and the Haringey Health Authority. Services were delivered by a number of NHS Trusts, Directly Managed Units (DMU) and General Practitioners (GP). On 1st April 1993, Haringey and Enfield Health Authorities merged to form the New River Health Authority which by 1st April 1996, merged with the Enfield and Haringey FHSA to form the Enfield and Haringey Health Authority (E & H HA.).

In order to provide an overview of the health issues in Enfield and Haringey during 1992 (when this study commenced) and 1996 (when the bulk of the study was completed), I have examined a number of relevant health authority annual reports and annual public health reports. In 1992, the Director of Public Health for Haringey Health Authority (an influential figure, who subsequently went on to become the Director of Public Health for New River HA and then Enfield and Haringey HA) wrote in her report that the year's attention had been drawn to the effects of unemployment and homelessness and the particular needs of newly arrived refugees. Emphasis was also given to the prevention and treatment of HIV and AIDS. The government White Paper *'The Health of the Nation'* published in 1992, prompted the Director of Public Health to state:

'The goals and aspirations of the Health of the Nation will act as a springboard for the future work of the districts of Enfield and Haringey'.

(p11)

'The Health of the Nation' was the conservative government's attempt to return to a public health approach which had been neglected in the previous six to seven decades, and which, as was discussed in the previous sections, would seem to be the most appropriate approach to deal with current issues affecting the public's health. A number of health policy commentators stated that in the 1980s the Thatcher government was formally committed to the WHO *'Health For All'* initiative but failed to formulate its own national strategy even though public health issues were almost a permanent feature of the political agenda in the late 1980s: AIDS, drug and alcohol abuse, smoking, food poisoning, environmental pollution and so on. The result of much of the thinking and planning of the late 1980s and early 1990s around public health -*'The Health of the Nation'*- was heavily criticised for focusing activities on easily measurable targets (Faculty of Public Health Medicine, 1991) around five categories: coronary heart disease and stroke, cancer, mental health, HIV/AIDS and sexual health, and accidents. The strategy explicitly makes the links between individual lifestyles and illness or disease but gives little indication of how the government would be using its considerable legislative and financial powers to promote health (Akehurst et al, 1991). Furthermore the targets appear to reflect a medical rather than a social perspective and thus fail to consider the role of inequality and social deprivation in ill-health. Hudson et al (1996) state that no clear commitments are made to improving poor housing conditions or reducing homelessness, whilst Francome and Marks (1996) observe the omission of any targets to narrow the differentials between people from different ethnic backgrounds. It can therefore be argued that the Director's of Public Health choice of *'The Health of the Nation'* as the springboard for the future work of the health authority was not the most appropriate framework for dealing with the identified key problem areas, such as unemployment, housing (both of which could be affecting the Greek

Cypriots living in the area) and the needs of refugees. Furthermore, neither the annual reports from the HAs and the FHSA nor the public health reports gave any indication as to how they had or intended to deal with these difficult social issues, the tackling of which requires a multi-sectoral effort and government support.

The 1993/4 Enfield and Haringey FHSA annual report introduced the joint planning which the FHSA had undertaken with the New River Health Authority which was created in April 1993 following the merger of Enfield and Haringey Health Authorities. The FHSA report identified the following priorities: Coronary Heart Disease and Stroke, Cancers, Accidents, Sexual Health, Mental Health, Tuberculosis, Diabetes, Sickle Cell and Thalassaemia, Disabilities, Asthma, and Substance Misuse. This list spelled out the areas -over and above those specified in the *Health of the Nation*-, which the FHSA in collaboration with the Enfield and Haringey HA had identified in 1993 and which were published in 1994 in a joint document entitled *'Committed To Your Future Health. Your Local Health Strategy'*. In 1993/4 the newly formed New River Health Authority published its first annual report. Much of the space in this short report was devoted to introducing the health authority's executive and non-executive members and reiterating the 11 areas of health priority which were identified by the health strategy. In his introductory letter, the Chairman noted that in its first year, the health authority had made progress in ensuring value for money for its residents, it had developed the primary care services, was dealing with the closure and reprovision of long-stay mental health hospitals, and it had developed a locally based health needs assessment process. In 1994/95 two key reports were published under the banner of *'Enfield and Haringey Health Agency'* which constituted the E&H FHSA and the New River HA who were due to merge by April 1996. The annual report focused almost entirely on the executive and non-executive members of the two authorities and the financial position of the two authorities. New River HA overspent its £207 million budget by £405,000, whilst the E&H FHSA had no overspent on its £71 million budget. A much more informative report was produced by the public health directorate of the two collaborating authorities. The main thrust of the report was the move towards a primary care led NHS, the trends in communicable diseases, the growing partnership between health

and other public services and voluntary organisations, and the 11 health priorities to which child oral health was added. By 1995/96, the annual health report announced that *'variations in health'* would be the theme for the report. Accordingly, there was a good attempt in the report to discuss health variations under each of the 11 health priorities. In her concluding remarks the Director of Public Health states:

> *Black and ethnic groups also experience poorer health for some specific conditions.... Asian, Black African, Black Caribbean and Cypriots are more likely to develop diabetes; sickle cell disease is restricted to Black African and Black Caribbean communities, as is thalassaemia to Mediterranean, including Cypriot and Turkish communities; some sections of the Irish community are particularly affected by alcohol dependency problems....The discrimination experienced by black and minority ethnic communities also means that they suffer higher levels of deprivation and unemployment and so are disproportionately affected by the health problems associated with these factors. There are particularly acute health and social problems faced by recent refugees.*
>
> (p37)

Her final recommendations were:

1. *Plans are drawn up for each of the eleven health strategy key areas to identify and prioritise options for most effectively addressing variations in health.*

2. *The health commissioning process demonstrates that resources are more clearly directed at reducing variations in health.*

3. *Close working relationships are further developed with primary health care teams, local authorities, providers and voluntary organisations to address the issues in this report.*

4. *The health authority works together with local authorities to monitor progress and to develop key indicators to measure achievements in reducing inequalities.*

(p38)

Thus, in this document the HA is placing greater emphasis on how to reduce variations in health, most of which invariably occur due to socio-economic and environmental factors as well as racism and discrimination. During the period of this study (1992-1996) the health services in Enfield and Haringey experienced a horrendous level of change. It is evident from the reports which I reviewed as compared with my local knowledge and the data I collected (Chapter 9) that many intentions remained just that, and many plans were not fully implemented or were well behind schedule. The disruption and discontinuity brought about by the various re-organisations as well as the need to respond to the government's short term politically driven goals, resulted in the apparent failure of any real progress to address some of the *'London'* issues, which were discussed above, at local level. In terms of addressing the health needs of MEGs, the introduction of ethnic monitoring for in-patients was delayed; the focus of needs analysis was the Health of the Nation's five key areas which was not only disease orientated but failed to identify the needs of large community groups such as the Greek Cypriots; although some general statements about culturally sensitive care were beginning to be included in the specifications of service delivery contracts, these failed to be monitored.

It is worth noting here the use of the term *'health variations'* in the 1995/96 public health report, as opposed to the previously used *'health inequalities'*. According to the Chief Medical Officer (1996) the term *'variations'* is essentially neutral and is used to describe factual information about health and health care. The term *'equality'* on the other hand is about comparisons between the level of health, or ability to obtain access to health care by individuals or groups. Health inequalities arise from the level of resources, housing conditions, dangerous working conditions, or exposure to environmental hazards. If *'variations'* is a neutral term, then *'inequalities'* is an emotive term as it implies equity and justice. On the basis of this explanation, I

would argue that the HA failed to address in any substantial ways the health needs of MEGs, for, in the case of the Greek Cypriots, it would be impossible to make comparisons between levels of health or to ensure access to health care, in the absence of demographic, epidemiological and cultural data, as well as ethnic monitoring data.

According to the E&H HA purchasing plan for 1996/97, most hospital care for the people of Enfield and Haringey is provided by the Chase Farm, North Middlesex and Whittington Hospital Trusts. A number of residents also use the Royal Free, St. Bartholomew's, University College and Middlesex Hospitals. Specialist London hospitals such as Moorfields and Great Ormond Street etc are also used. Most health care in the community is provided by 226 general practitioners, of whom 57 (21%) are single handed and the rest are in groups of up to 8 partners. Community care is also provided by the Enfield Community Care and Haringey Health Care Trusts, as well as by high street dentists, pharmacists and opticians. The health authority also works closely with the two local authorities in Enfield and Haringey in planning to meet the health and social needs of the population. Increasingly they are forging broader alliances to promote good health.

Much of the information in the following section is based on the New River Health Authority's sector profiles (1993), the London Borough of Enfield 1991 Census Summary Paper No:3 on Ethnic Minorities (1993), the Haringey Council's Economic and Social Assessment (1995), and the Enfield and Haringey Health Authority's Annual Health Report (1995/6). It is included here as a useful background information about the area in which the study took place. The absence of any specific data about the Greek Cypriot community which was discussed earlier, is illustrated in this profile. The effects of this unsatisfactory situation are implied but some examples are provided in order to make these more explicit. Issues around population profiles are discussed further in Chapter 6.

ENFIELD AND HARINGEY HA POPULATION PROFILE

In this section and its sub-sections some key demographic and epidemiological data are presented and analysed with particular attention given on their relevance to MEGs, in the recognition that there may be similarities in trends or issues affecting all MEGs including the Greek Cypriots living in the area. As can be seen in Chapter 6, this type of information is crucially important for health purchasers and providers who are required to provide appropriate, equitable, accessible, effective and efficient local services.

The Enfield and Haringey Health Authority is divided into five sectors, each with a population of approximately 100,000 people (range 79,894 to 102,719). Of these, two sectors are in the London Borough of Haringey and are coterminous with the parliamentary constituencies while the London Borough of Enfield's three sectors follow the boundaries of the local authority's social services areas. The five sectors are: West Haringey (Hornsey and Wood Green), East Haringey (North and South Tottenham), North Enfield (East and West Enfield), West Enfield (Southgate and Palmers Green) and East Enfield (Edmonton and Ponders End). This sector arrangement enables information to be collected and to be shared with other agencies, particularly the local authorities in a compatible way which is imperative as joint planning and commissioning is becoming more common, in line with government policy.

The resident population of the two Boroughs on the 1991 census night was 459,621. There were 221,470 males and 238,151 females. In the 1995/6 annual health report, it is reported that the population of Enfield and Haringey was 472,100. The population is expected to rise again by the year 2000 because of the above average population growth now being experienced in Inner London. The main changes at the end of the century are predicted to be marked increases in the 5-14 (by 12%) and the 85+ age groups (by 10%). These changes are significant as children and the very old are two groups with greater health needs than most (E & H HA Annual Report 1995/6). In terms of size, the Enfield and Haringey Health Authority is the fifth largest in London (out of 16 health authorities) after South East London H.A. with a

population of 729,000, Ealing, Hammersmith and Hounslow H.A (648,000), Merton, Sutton and Wandsworth H.A. (614,000) and East London and the City H.A. (591,000).

Table 3.1 provides a more detailed picture of the population in each of the five sectors based on the population estimates for 1991. The figures show that East Haringey has the highest numbers of 0-24 year olds, whilst West and North Enfield have the lowest. The picture is reversed in terms of those aged 65+. Table 3.2 below, shows that the highest percentage of persons in households headed by a Cypriot, is West Enfield. This may indicate that more Greek Cypriots of the 65+ age group live in West Enfield, the most affluent of all sectors within the Enfield and Haringey HA's catchment area.

Table 3.1: **Mid-Year Population Estimates by Sector, 1991.**

Age Group	East Enfield	North Enfield	West Enfield	East Haringey	West Hrng
00-04	7900	5500	5000	8100	7300
05-14	12000	9600	10000	12700	10800
15-24	14000	11700	12400	17100	16300
25-44	31100	24800	25600	36200	41300
45-64	18500	17300	18500	18800	19100
65-74	6500	6700	7000	6200	6500
75-84	4700	4700	5300	3900	4700
85+	1300	1300	1700	1200	1600
Total	**96000**	**81600**	**85500**	**104200**	**107600**

Source: OPCS, 1991 Census, E&H Annual Health Report 1995/6

As some ethnic groups can be more subject than others to particular health problems, the composition of the population is important in planning health services. For example, as noted above, West Enfield has the highest percentage of Greek Cypriot households. This being the area with the highest numbers of individuals above the age of 65, it is quite likely that a large number of Greek Cypriots would be first

generation older people who may have language problems and, who most likely have a strong Greek Cypriot identity. As will be argued further in this thesis, ethnic identity is an important influencing factor when it comes to health beliefs and behaviours. According to the 1991 Census, nearly 34% of the population of Enfield and Haringey belong to minority ethnic groups. Details are given in Table 3.2.

Table 3.2: **Ethnic Groups in Enfield and Haringey by Sector, 1991.**

Ethnic Group	Enfield & Haringey %	East Enfield %	North Enfield %	West Enfield %	East Hrng %	West Hrng %
White (Excl, Cypriot, Turkish and Irish)	66.2	66.6	86.3	69.1	45.9	67.4
Black Caribbean	6.1	7.0	1.9	1.6	13.7	5.0
Black African	3.3	2.8	0.6	1.2	8.0	3.1
Black Other	1.5	1.5	0.5	0.6	3.1	1.6
Indian	3.6	3.6	1.5	5.3	3.9	3.3
Pakistani	0.5	0.5	0.2	0.5	0.9	0.6
Bangladeshi	1.1	1.2	0.3	0.8	2.0	1.1
Chinese	0.7	0.4	0.3	0.6	1.2	1.0
Other Asian	1.8	1.9	0.6	1.5	2.6	1.9
Other	2.0	1.9	0.8	1.4	2.9	2.5
Persons in households-'headed by Irish'	5.1	4.0	3.1	4.7	6.4	6.6
Persons in households-'headed by Cypriot'	6.9	7.6	3.6	11.8	6.8	4.7
Persons in households-'headed by Turkish'	1.2	1.0	0.3	0.8	2.6	1.3
	100.0	100.0	100.0	100.0	100.0	100.0

Source: 1991 Census Local Base Statistics, E&H Annual Health Report 1995/6

The largest minority ethnic groups in Enfield and Haringey are Cypriots (6.9%), Black Caribbean (6.1%), Irish (5.1%), Indian (3.6%) and Black African (3.3%). More specifically those who reported -in the 1991 census- as having a Cypriot heading their household in Haringey represent 5.7% (11,593) of the total population, whilst in Enfield they represent 7.9% (20,400) of the total population. It is not possible to differentiate between Greek and Turkish Cypriots as the 1991 census, did not have the Greek Cypriot and Turkish Cypriot as a category but merely asked individuals to denote the country of birth of their head of household. However, in January 1994, the environmental services of the London Borough of Enfield (LBE) adjusted the available census figures for Cypriots and reported them to be 9.5%

(25,000) of the total population. Furthermore, LBE was able to calculate -based on a survey of local schools- that the ratio between Greek Cypriots to Turkish Cypriots was 4:1(LBE 1990). As will be seen from a later section in Chapter 4, the Greek Cypriot community regards these figures as a gross underestimation of its size. Nevertheless, even if these figures were to be taken into consideration, it becomes clear that the Health Authority cannot ignore the needs of its largest minority ethnic group and must take steps to respond to the challenge of establishing more accurately the size of this community, of effectively identifying its needs, and of responsibly responding to them.

Deprivation in Enfield and Haringey

Social deprivation measurements are widely used within the NHS. The Jarman Index (Jarman 1983) is normally used to provide an indication of the relative deprivation of an area and is calculated using the following information: unemployment, number of unskilled people, those living in overcrowded accommodation, single parents, a population aged under 5 years, lone pensioners, people who have changed address in the last year and ethnic minorities. The score for England and Wales is 0, with a figure > 0 suggesting a relatively higher level of deprivation than the national average and a minus figure suggesting an area that is comparatively more prosperous. Based on the 1991 census Enfield and Haringey had a combined score of 14.7. However this varies between -13.8 (Grange ward in Enfield) and a score of 45 (Seven Sisters ward in Haringey). Haringey had a higher deprivation rating than Enfield, the scores being 27.4 and 5.7 respectively. Both Enfield and Haringey had higher deprivation scores in 1991 than in 1981. Edwards and Flatley (1996) inject a note of caution in the use of deprivation indices particularly the over-reliance on a single one. They point out that the spatial level at which analysis is disaggregated may be an important determinant of the amount of deprivation. Thus, averaging scores across a borough, can hide significant variation. For example, boroughs with low deprivation scores often have one or two highly deprived areas. The Jarman Underprivileged Area (UPA) Index was specifically designed as a measure of health needs but has been widely used both as a measure of health and general deprivation. It has also been used to help determine the allocation of funds in the Health Service. The Jarman

score is a simple additive index which is obtained by multiplying each component by a different constant before adding them together. The London Research Centre (LRC) suggests that a weighted index is a more sensitive indicator of deprivation; they used factor analysis to identify six principal factors: economic stress (the most relevant), children in families, manual workers, pensioners, ethnic minorities, and housing stress (Edwards and Flatley 1996).

The LRC index is not used by the E & H HA. Using data from the 1991 Census, its 1995/6 annual report does provide some useful indicators by sector. For example East Enfield has a relatively high proportion of Black Caribbeans and Cypriots (33%). It has the third highest owner occupancy in E & H, has the lowest proportion of people living alone but a relatively high number of single pensioner households. 38% of the households do not own a car and 13% are unemployed. North Enfield has the lowest number of black and minority ethnic residents (14%), a high proportion of single pensioner households but a relatively small number of single households. Owner occupancy stands at 74% (second highest), only 29% of households do not own a car, and unemployment is relatively low at 9%. West Enfield has the largest number of people aged 85+. MEGs form 31% of the population, the highest being the Cypriots (12%). Single pensioner households are relatively high; owner occupancy is the highest in the area at 79%, while 28% of households do not own a car and only 9% are unemployed. East Haringey has the second highest proportion of 0-14 year olds and the lowest aged 75+. It has the highest number of black and minority ethnic residents (54%), the lowest owner occupied levels at 46% and the highest numbers not owning a car (57%). It has a high level of single households and the highest unemployment in the district at 22%. West Haringey has the highest number of residents of child-bearing and rearing age (54%). It has a relatively high level of residents from MEGs (33%), the highest percentage of Irish residents (7%) and the highest number of single households. Only 53% own their homes while 44% do not own a car and 16% are unemployed. Unfortunately none of these figures are broken down into ethnic categories. Some tentative associations may be made:

a) the sector with the highest number of residents from MEGs has the highest level of deprivation,
b) the sector with the highest number of young adults also seems to suffer high levels of deprivation and,
c) the sector with the highest number of Greek Cypriots is the least deprived.

Taken as a whole, the figures in Enfield and Haringey seem to paint a better picture than that of the overall Inner London discussed earlier.

Births and Deaths in Enfield and Haringey

The general fertility rate for Enfield and Haringey in 1994 was 65.6 (per 1000 women aged 15 years to 44 years), which was higher than that of the whole North Thames region (63.2) and that of England and Wales (61.8). In 1994 there were 7240 live births (3750 in Enfield and 3490 in Haringey) this represents a fall from 7543 in 1992 and 7345 in 1993. As was discussed earlier this higher than average birth rate is having a cumulative effect on the population profile, the implications of which will need to be taken on board as soon as possible. This trend is also important in view of the fact that MEGs have a younger age profile and a higher average number of children per household (Jones 1993). The live birth rate for Enfield and Haringey 1994 was 15.4 which was higher than North Thames (13.8) and England and Wales (12.9). Table 3.3 gives further information on births and deaths. It shows that, particularly in Haringey, the proportion of low birth weights, infant and perinatal mortality rates are higher than the national average. There is now evidence to link these indicators to deprivation (Wilkinson 1994, 1996). Furthermore, Balarajan and Soni Raleigh (1993) stated that the perinatal mortality rate of black and ethnic minority babies is higher than those babies with white indigenous parents. Figures related to the Greek Cypriots are not available.

Table 3.3: **Infant Births and Deaths**

	Enfield	Haringey	North Thames	E & W
Stillbirth ration	4.0	5.1	5.7	5.7
% of births < 2500 Grams	7.5	8.0	7.2	7.3
% of births < 1500 Grams	1.1	1.7	1.2	1.1
Infant mortality rate	5.6	8.0	5.4	6.2
Perinatal mortality rate	6.6	9.4	8.3	8.9

Source: OPCS VS1 and VS2, E&H Annual Health Report 1995/6

During 1994, 4236 residents of Enfield and Haringey died, of them 2010 were men and 2226 were women. Table 3.4 gives the causes of deaths.

Table 3.4: **Cause of death of Enfield and Haringey Residents 1994**

Cause	Males	%	Females	%	Persons	%
Diseases of circulatory system	804	40.0	936	42.1	1740	41.1
Neoplasms	547	27.2	496	22.3	1043	24.6
Diseases of respiratory system	331	16.5	347	15.6	678	16.0
Diseases of digestive system	54	2.7	90	4.0	144	3.4
Injury and poisoning	83	4.1	42	1.9	125	3.0
Symptoms, Signs and ill-defined conditions	20	1.0	62	2.8	82	1.9
Diseases of nervous system and sense organs	32	1.6	44	2.0	76	1.8
Mental disorders	19	0.9	53	2.4	72	1.7
Diseases of genitourinary system	27	1.4	38	1.7	65	1.5
Endocrine, nutritional, metabolic and immunity disorders	21	1.0	43	1.9	64	1.5
Infectious and parasitic diseases	26	1.3	22	1.0	48	1.1
Other	27	1.4	43	1.9	70	1.7
All causes ages under 28 days	19	0.9	10	0.4	29	0.7
Total All Causes .	**2010**	**100.0**	**2226**	**100.0**	**4236**	**100.0**

Source: OPCS Table VS3, E&H Annual Health Report 1995/6

The average standardised mortality rate (SMR) for Enfield for all persons under the age of 75 for the years 1988-92 was 91 whilst Haringey's was 102 which gives an average for E & H H.A., of 96.5. This score is better than the national average set at 100. The highest score in London is 127 (Tower Hamlets) and the lowest is Harrow

(81) (Public Health Census Data Set 1993). The 1991 Census also reported that 10.7% of Enfield residents and 11.6% of Haringey residents reported to have a limiting long-term illness. These figures compare favourably with the overall rates in inner London (12.3%) and outer London (10.7%).

Data presented in tables 3.3 and 3.4 constitute essential information of any population profile. For example, when constructing a specific population profile for the Greek Cypriot community, as is suggested in this thesis, general population statistics form the basis for comparisons. Thus, questions should be asked as to how the infant birth and death rate, or the rate of other causes of death of the Greek Cypriots compares with that of the overall area statistics. If any rates are different, either in a positive or negative sense, these could be investigated, lessons learnt and appropriate action taken.

Households and Housing in Enfield and Haringey

According to the New River HA (Sector Profiles 1993), there are approximately 187,000 households in Enfield and Haringey. West Haringey has the largest number of households at 45,132 (24%) whilst North and West Enfield have the smallest number at (17.1% and 17.6%) respectively. There are 54,174 pensioner households which represent 16% of the population which is slightly lower than that of London as a whole (16.8%) or England (18.4%). Just over a third of all pensioners (34.7%) live alone, West Haringey has the largest number of lone pensioner households.

Almost two thirds of households in Enfield and Haringey are owner occupied, just over 12% are rented privately and a little under a quarter are rented from housing associations and local authorities. Residents in the London Borough of Haringey are less likely to be owner occupiers (49%) compared to those living in the London Borough of Enfield (74%). However, according to the 1991 Census, 1.7% of all Enfield households in permanent accommodation and 4.3% of Haringey similar households are without basic amenities. Although Enfield compares well with the overall rate for outer London (1.8%), Haringey is in much worse condition than the

overall rate for inner London which stands at 3.3%. Only Newham has a higher rate than Haringey (4.7%).

In Haringey the total number of households in temporary accommodation at the end of March 1994 was 2,745. This compares with 882 households in Enfield at the same time period. Family break-up is still by far the largest single cause of homelessness in both Enfield and Haringey. In Haringey, a higher percentage from the black and minority ethnic groups are homeless compared with the rest of the residents, with African households being the largest group (22% of the total). However the figures greatly underestimate the number of homeless people in Enfield and Haringey since councils have no duty to house homeless people such as single people and childless couples who are not categorised as *'priority'*. There are no reliable estimates for the number of people *'sleeping rough'* for either Enfield or Haringey (New River HA, Annual Report 1994/95).

The information provided by the above sources does not give details about the Greek Cypriot community. However as can be seen in Chapter 8 of this thesis, house ownership amongst this community is very high at 84%. It is suggested that this reflects the importance which this community places on home ownership, which may be a cultural phenomenon. However, there are a number of other issues which result from this which need to be taken into consideration. As can be seen in Chapter 8, home ownership for the Greek Cypriots is not necessarily an indicator of affluence.

Economic Activity in Enfield and Haringey

Within the Enfield and Haringey Health Authority catchment area there are 368,520 individuals over the age of 16 years, 64% of whom are economically active and 36% economically inactive. Being economically active means that a person is classified as able and available to work and is either employed, on a government scheme or unemployed. Economically inactive persons include students, persons who are permanently sick, persons who are retired and persons who are economically inactive for other reasons, e.g. women staying at home during their child bearing and rearing years. The 1991 census unemployment rate for the total London population was

11.6%. The unemployment figures for the Enfield and Haringey catchment area by ethnic groups are presented in Table 3.5. Separate census data on the economic activity of Cypriot, Irish and Turkish residences are not available (New River HA, Sector Profiles 1993).

Table 3.5: **Unemployment by Ethnic Groups in Enfield and Haringey**

Ethnic Groups	**%**
White (incl; Irish & Cypriots)	< 10
Black Caribbean	12
Black African	21
Black Other	17
Indian	10
Pakistani	12
Bangladeshi	22
Chinese	< 10
Asian Others	< 10
Other	13

Source: 1991 census local base statistics table 9, New River Sector Profiles, 1993

In September 1994, there were 35,753 people officially registered as unemployed in Enfield and Haringey, 14,402 (11.1%) in Enfield and 21,351 (20.2%) in Haringey. The unemployment rate of all non-white persons in 1991 were: Enfield 14%, Haringey 24.4%; only five inner city areas had higher rates than Haringey. The London Research Centre (LRC) reports that in April 1995, 7.5 % of full-time employees in Enfield were earning below £4.26 per hour whilst the corresponding figure for Haringey was 10.3 % which is the third highest in London. The LRC also reported that in 1994 22.3% of persons below the age of 60 living in Enfield, were receiving income support; the corresponding figure for Haringey was 39.3 % making it the second highest in London. As was discussed earlier in this chapter Benzeval et al (1995) and Eames et al (1993) suggested that deprivation is linked to higher rates of disability and death, not only for adults but also for their children.

Social Class in Enfield and Haringey

According to the 1991 census, Enfield has a higher proportion of residence in social class I, II and IIIM (manual) than Haringey, were as Haringey has a higher percentage in social classes IIINM (non manual), IV and V (Table 3.6).

Table 3.6: **Proportion of population by social class**

Social Class	Enfield	Haringey
I and II	30.3%	24.5%
III NM	23.3%	39.0%
III M	31.4%	16.0%
IV and V	14.9%	18.3%
Others N/S	0.0%	2.1%

Source: 1991 Census Local Base Statistics, New River HA and E&H FHSA Annual Report 1994/5

Social class, based on the type of an individual's occupation, is an indicator predictive of health beliefs, illness and health behaviours and mortality, used by the government at national and local levels and by health authorities, to make policy and to determine strategy. Social class is strongly linked to the socio-economic status of an individual, and is also often used as a framework to explain power relations. Wilkinson (1996) has argued that people in the lower social classes have fewer life chances, thus in most industrial societies which have such stratification systems, the opportunities for health, long life, educational success, fulfillment in work are all unequally distributed in systematic ways. Smaje (1995) although in agreement that those in the lower social classes tend to be those in the worst socio-economic positions who subsequently suffer more illness and disability, refers to Marmot et al (1984) who found that the class *'gradient'* which is typically seen in the general population was far less clear in the migrant groups. They suggested that material factors alone are insufficient to explain ethnic differences in health status. Pfeffer and Moynihan (1996) explain that social class classifications may be misleading with respect to ethnic minorities. They were devised in Edwardian England and reflect social values and conditions that prevailed at the time and are thus insensitive to the social and material circumstances of people from MEGs. For example, working in a small business places people in

social class two, but minority ethnic businesses are often marginal and their owners may be quite poor.

The use of the existing social class system based on occupational category, may not be a good indicator for conceptualising and explaining the health status of the Greek Cypriots nor for the health inequalities which they may suffer. Anthias (1992) observed that the ethnic dimension informs the Greek Cypriots' personal relations and attitudes much more than any strong class divisions. Based on my understanding of the Greek Cypriot community and some of the data which were obtained during the exploratory phase of this investigation, a number of more relevant indicators were used for the survey (Chapter 8) such as income, education, housing tenure, gender, marital status and age. In addition as can be seen from the next chapter, a more detailed cultural, social and historical analysis is needed to understand any inequalities which may exist, as well as the health beliefs and lifeways of this minority ethnic group.

SUMMARY

This chapter examined some of the major NHS changes brought about by the conservative government during the 1980s and early 1990s. The chapter also examined the main issues and factors which influenced the health of Londoners during these years, particularly those from minority ethnic groups. The evidence seems to suggest that the NHS reforms were driven by an ideology which primarily aimed at reducing costs whilst at the same time curtailing the powerful position of the medical profession. Although the reforms recommended that health purchasers and providers paid attention to the health needs of people from minority ethnic groups, they nonetheless failed to make much impact as they failed to adequately address the socio-economic, environmental and cultural variables which many commentators considered just as important (if not more important) to health, as the bio-pathological status of individuals. This was illustrated in the discussion on the London-wide health issues.

The chapter considered some of the demographic and epidemiological data relevant to Enfield and Haringey HA, this being the area of London where this study is located. These data were related to the health policy of the HA. It was pointed out that the lack of data about the Greek Cypriot community could make any attempt in planning or providing appropriate services for this community, a difficult task.

Chapter 4 deals with the ethnohistory of the Greek Cypriot community living in Britain. The aim of the chapter is to provide some information about this minority ethnic group which hopefully will contribute towards the reader's understanding of the health beliefs and lifestyles of this group, which are discussed in later chapters.

CHAPTER 4

THE ETHNOHISTORY OF THE GREEK CYPRIOT COMMUNITY LIVING IN BRITAIN

INTRODUCTION

This chapter provides an overview of some historical, geographical and sociological factors which are deemed important if one is to understand the influences of culture on the health of the people under study. Leininger (1991) defines ethnohistory as:

> *"...those past facts, events, instances, experiences of individuals, groups, cultures, and institutions that are primarily people-centred (ethno) and which describe, explain, and interpret human lifeways within particular cultural contexts and over short or long periods of time"*
>
> (p48)

In keeping with this definition, this section also includes a discussion on the identity of the Greek Cypriots living in Britain.

McNaught (1987) states that migrant communities have particular problems associated with the process of migration and adjustment to life in a different society. He adds that certain physical and psychological problems have long been associated with migration, apart from the more practical problems of language difficulties; it is therefore very difficult to explore the health care of ethnic minorities, in this case the Greek Cypriot community, without paying attention to the impact of the process of migration. Such exploration is paramount particularly as the health care professions' ability to deliver adequate and appropriate health care to Britain's multi-racial, multi-cultural population has recently been questioned (King's Fund 1990).

BRIEF OVERVIEW OF THE GEOGRAPHY AND HISTORY OF CYPRUS

Cyprus is a relatively small island in the most eastern end of the Mediterranean Sea with an area of 9,251 square kilometres. It is 380 kilometres north of Egypt, 105 kilometres west of Syria and 75 kilometres south of Turkey. The Greek mainland is some 800 kilometres to the west. The population of Cyprus at the end of 1990 was 706,900. Population distribution by ethnic group is 81.6% Greek Cypriots including Maronites, Armenians, Latins and others and 18.4% Turkish Cypriots (Press and Information Office, Republic of Cyprus 1992).

To the north of the island a narrow mountain range called Pentadactylos dominates the landscape, rising to a height of 1,024 metres. In the south-west the extensive mountain massif of Troodos, culminates in the peak of Mount Olympus, 1,952 metres above sea level. Between the two ranges lies the fertile plain of Messaoria to the east and the still more fertile irrigated basin of Morphou to the west. The principal crops in the lowlands are cereals, vegetables, potatoes and citrus. Vineyards occupy a large area on the southern and western slopes of Troodos mountains. In the past two decades, tourism has become an important industry for the Cypriot economy.

Cyprus has a rich history and culture, the result of many influences over thousands of years. Georgiades (1978) stated that the earliest traces of human habitation in Cyprus belonged to the Palaeolithic Age and date from about 7,000 BC. Since then the history of Cyprus is as varied as it is interesting. The Chalcolithic Age (3900-2500 BC) marks the discovery of copper in Cyprus, and was followed by the Bronze Age (2500-1050 BC), when Cyprus was firmly established as a centre of cultural and commercial exchange between east and west. The island's importance was underlined at the beginning of the fifteenth century BC when it became subject to the Egyptian Pharaoh Thotmes III, who received a tribute mainly in the form of copper. In general it was a period of peace and great prosperity.

'*Cyprus, 9000 years of history and civilisation*' (Cyprus Tourism Organisation 1991) has reported that the Mycenean and Achaean Greeks settled in Cyprus around the 14th century BC. They settled at first in the east and northeast but gradually spread

throughout the island. Following the conclusion of the Trojan War, various legendary Greek heroes visited the island, where they were associated with the foundation of great cities such as Salamis, Kourion and Paphos. The Achaean Greeks had a profound and lasting influence on the culture of Cyprus. They introduced their language, religion and customs. Between the 8th century BC and the death of Christ, Cyprus was ruled by the Phoenicians, the Assyrians, the Egyptians, the Persians, and the Ptolemy dynasty.

After the death of Christ, the Apostles undertook missionary journeys. St. Paul traveled to Cyprus where he was joined by St. Barnabus and St. Mark. The island was the first country to have a Christian Ruler when Sergius Paulus was converted. The Greek Orthodox Church stems from Cyprus.

Cyprus became part of the East Roman Empire, referred to as the Byzantine Empire (330-1184 AD). The Byzantine Empire was dominated by the Greeks and this influence contributed to the continuation of the Greek culture in Cyprus (Larousse Encyclopedia of Ancient and Medieval History 1966, Webster's Family Encyclopedia 1991). Galatariotou (1993) states that in the last two centuries of Byzantine rule in Cyprus contact with Europe became increasingly pronounced due to the Crusades. Cyprus ports were used by the crusading armies as places for launching missions or resting after them, and as a safe place for refugees. Cyprus was also a convenient meeting place for negotiation between warring factions. Cyprus was also a reprovisioning centre for the crusading armies. In 1191 the King of England Richard I *'the Lionheart'* captured the island and sold it to the Lusignans in 1192. Koureas (1993) observes that although during this period Cyprus was politically, legally, administratively and economically an integral part of Western Europe, cultural fusion between the Franco-Latins and Greeks on Cyprus was negligible due to the religious and cultural barriers that had evolved between them in the wake of their conquest which continued to exist and deepen in subsequent years.

In 1489 Venice took control of the island. By 1571 Cyprus fell to the Ottoman Turks. Dionyssiou (1993) writes that the three centuries of Ottoman rule was an era

characterised by a total lack of progress, the result of maladministration and exploitation of the population. Despite the hardships of Ottoman rule, the Greek Cypriots preserved their cultural identity by remaining attached to their religion and language. The seventeenth century was a period of almost general illiteracy not only in Cyprus but also in much of Western Europe. However, under the auspices and influence of the Orthodox church, many schools were set up by the eighteenth century. The Turks handed Cyprus over to Britain in 1878 for an annual rent of £96,000. The island was annexed in 1914 and became a British colony in 1925. According to Georghallides (1993), social and economic progress was painfully slow during British rule. The island was starved from any investment. In addition Britain's sympathy to Turkey's territorial and political claims, raised nationalist feelings in the Greek Cypriots. A political movement demanding '*enosis*' (to become part of Greece) was established. Following a long and bitter struggle, Cyprus gained its independence in 1960.

The 1960 Constitution of the Cyprus Republic proved unworkable in many of its provisions, and this made impossible its smooth implementation. When in 1963 the President of the republic proposed some amendments, the Turkish ministers withdrew from the Cabinet. In 1974, a coup was staged in Cyprus by the Military junta, then in power in Athens. Turkey, responding to calls from the Turkish Cypriot leadership, invaded the island. The Greek Cypriots from the north became refugees and moved to the south and the Turkish Cypriots from the south moved to the north. This situation remains today (Press and Information Office 1992). Today, efforts to find a solution to the international problem posed by the division of Cyprus continue under the auspices of the United Nations Secretary-General. In 1990, Cyprus submitted an application for full membership of the European Union. Cyprus looks forward to being recognised and accepted as a member of the enlarged family of Europe and the healing of the island's sad division (Epaminondas 1993).

MIGRATION OF CYPRIOTS TO BRITAIN

Immigration for the Greek Cypriots is a very old phenomenon (Panayides 1988). This is exemplified by the figures from a survey published by the Ministry of Education in Cyprus (cited by the Cyprus High Commission 1986) which gave the Cypriot population in London as being:

1911	208	1941	10,208
1921	334	1961	41,898
1931	1059	1964	78,476

The first major group of Greek Cypriots who emigrated to Britain arrived in the 1930's. As Cyprus was a British colony, young men seeking employment made their way to Britain. They primarily settled in the Camden Town and Soho areas but later spread to Islington and Hackney and northwards to Haringey. With the depression of the thirties, the immigrants faced acute housing and employment problems. Those who could find work, became cleaners, waiters or chefs in restaurants and hotels. Others found employment in the *'rag trade'* and some managed to start their own business.

The second wave of emigration occurred in 1960-61 when 25,000 Cypriots left for Britain at the time Cyprus became a republic, but this was reduced to less than 2,000 a year under the Commonwealth Immigrants Act 1962. By 1974 it was estimated that there were 120,000 Cypriots in Great Britain of whom five out of six were of Greek origin and the other was Turkish. The last wave of emigration occurred in 1974 following the troubles between the two communities when as mentioned earlier, almost 50% of its people became refugees.

In 1986, the Cyprus High Commission reported that there were some 200,000 Cypriot-born persons and descendants of Cypriots (of Greek and Turkish origin), living in Britain. In 1996, the Greek Orthodox Archdiocese reported that in London alone, there are in excess of 250,000 Greek and Greek Cypriot people. Two thirds of these live in North London (around 167,000). These figures are derived from church

attendances, numbers of weddings, baptisms and requiems performed as well as by the number of children attending the church run and the independent Greek schools (Unverified unpublished statistics, Greek Orthodox Archdiocese, 1996). However, there are large communities in many other cities particularly Birmingham, Bristol, Manchester, Great Yarmouth and Glasgow.

THE GREEK CYPRIOT IDENTITY IN BRITAIN

As discussed above, most Greek Cypriots migrated to Britain for economic reasons. Anthias (1992) states that unlike some other migrant groups, they did not expect to be welcomed with open arms. Their liberation struggle against the British during the 1950s gave them a sense of familiarity but also estrangement from the colonial power. Those shared experiences forced them to stick together socially, economically and politically, factors which contributed towards the maintenance of the Greek Cypriot culture. Not only were they marginalised within the British society due to the anti-Cypriot climate which prevailed at the time, their inability to speak English and their low marketability, but they also chose to exclude themselves from it, both as a protective mechanism and as means through which they could gain social support and employment. The refugees who arrived from Cyprus after the 1974 political conflict between the Greek and Turkish Cypriots and the subsequent war and displacement of large numbers of people, added a new dimension to the *'British'* Greek Cypriot community and a strong cause for solidarity. The Cyprus national issue which remains unresolved, is even today one of the main forces for the *'oneness'* which Hall (1990) describes the position which defines cultural identity in terms of one, shared culture, a sort of collective *'one true self'*, hiding inside the many other, more superficial or artificial *'selves'* which people with a shared history and ancestry hold in common.

Over the years the Greek Cypriot immigrants proved how much they value their own culture by the considerable efforts they take in order to preserve it. The first generation of immigrants were remarkably successful in recreating the environment of Cyprus in their family lives and communities which protected them against the usual

forces of assimilation. Anthias (1988) comments that the Greek Cypriot community is held together by the shared history, culture, language, religion and an almost romantic devotion to Cyprus where almost all dream to returning one day. Although there have been concerns about the identity of the 2nd and 3rd generation Greek Cypriots, the community seems to be furiously tackling any understandable changes, through the work of the many Greek Cypriot organisations, Greek schools and the Greek Orthodox church. In 1988 at a conference entitled *"Issues of identity"*, hosted by the then Polytechnic of North London and organised by the National Federation of Cypriots in Great Britain, the late Dr Homer Habibis (a well respected and long standing community leader and activist), said of the 2nd and 3rd generation of Greek Cypriots in the United Kingdom:

> *"If there is a subject which is so important for the future of our community, it is the subject of the children and grandchildren of the first generation of immigrants who will be the Cypriot Hellenism of the future. There always exists a barrier between the generations and we are no exception. However there is a basic difference between the Greek Cypriots of the first generation and their children and grandchildren who were neither born nor lived in Cyprus and who have not experienced in full the Greek Cypriot way of life and do not have the same sentimental attachment to Hellenism. Moreover they did not experience the reality of the struggle for liberation during the last forty years and of the tragedy and aftermath of the Turkish invasion. If we want to influence them and transmit to them our national identity we must try to understand them, we must try to see how they think, what are their feelings for Cyprus, Greece, and the Greek world in general and how they see us, their parents, who as time goes by will be diminishing in numbers.*
>
> *We hope that in this way we may be able to help them to accept the reality of their origin and come to terms with their environment in which they have been born and to feel that they belong somewhere*

and that they have a defined identity, religion, traditions and ethos and a moral code which they should try to follow. If they have a sense of belonging then they are more likely to develop emotional balance, satisfaction and happiness in their lives. The identity of the second and third generations is bound to be different from that of the first. They will acquire many of the characteristics of the environment of the country in which they were born and these will enable them to grow up well adapted in British society".

(p6-7)

Dr Habibis was acknowledging the fact that whilst cultural continuity is important it should not be synonymous to cultural stasis. It could be argued that in urging the first generation members of the Greek Cypriot community to tackle the inevitable cultural changes in the 2nd and 3rd generation (and beyond), he was articulating the two sides of the cultural identity coin: the side of similarity/continuity and the side of difference/change. Rutherford (1990) stated that cultural identity - if it is to be productive- can never be some static unchanging object. It is a transforming process; for, if it were to remain static it would lose its ability to innovate.

Hadjimichael (1992) has pointed out that identity is a complex process conducted in or through a multitude of dynamic social relationships and expressed through a diverse range of creative and negotiation processes. He also adds that identity is something politically defined, through perspectives and practices, relationships of power, access and representation. In his view, the Greek Cypriot *'community identity'* is almost controlled by the large number of influential organisations and institutions such as the London Greek Radio and community's newspaper *'Parikiaki'*, all of which on the whole present a traditional identity which fails to acknowledge the contribution and the needs of the British born and bred Greek Cypriots. He also points out that a generational outlook to identity is fundamentally ageist and too static. Agendas based on first, second, third and fourth generation identity, ought to be more usefully replaced with agendas from new groups dealing with issues of

gender, sexuality, special needs, arts and youth which will result in richer and more varied understandings of Cypriot situations in British society and will dispel the previous homogeneous stereotype of what Greek Cypriots are culturally.

Anastasi (1992) has highlighted the issues of identity for the second and third generations by challenging the emphasis placed on identity crisis, cultural conflict, language and communication problems which represent some of the key constructs within which the pathology of the Greek Cypriot community is developed and embodied by many first generation community leaders and Cypriologists such as Oakley (1970, 1987). This narrow and almost simplistic cultural framework has restricted the possibilities of meeting the needs of young Greek Cypriots through its influence within the broader society and authorities who generally support and fund ethnic projects only when they are presented with a problematic situation.

SUMMARY

A number of issues have emerged from the previous brief analysis: the complexity of influencing factors in the development and maintenance of the Greek Cypriot ethnic identity, its effect on lifestyles, the acknowledgement of differences between generations and possible conflicts which may arise, the dangers of pathologising the Greek Cypriot identity, and the importance of reconceptualising it within a broader framework which includes and emphasises issues which individuals born in Britain can identify with. Most relevant to this investigation, is the impact of identity on lifestyles and its consequent effects on health. Connected to this, is the way society views, relates and reacts to the Greek Cypriot community through the collective identity transmitted by the group (intentionally or unintentionally), and the way that individual members of the group live their ethnic identities. The two are of course not exclusive of each other. The lived experiences of individuals influence the way the collective is projected often for political and economic reasons. In its attempts to obtain resources or favourable political decisions, the Greek Cypriot community will often appeal to bonds of common cultural experiences in order to mobilise the community, and will emphasise specific cultural needs to those who hold the power.

In so doing however, they are, as Anastasi (1992) observed, perpetuating stereotypes and essentialism. The question: *'is the adoption of strategic essentialism morally wrong if it manages to provide resources which may lead to the empowerment of the community'*, remains unresolved.

The next chapter takes a closer look at the broader impact of culture on health beliefs, lifestyles and health status and considers the contribution of the two approaches - multi-culturalism and anti-racism - which dominated the debate around the health of minority ethnic groups during the last three decades. The current approach which emphasises *'inequalities'* and *'citizenship rights'* is also discussed.

CHAPTER 5
CULTURE, ETHNICITY, RACISM AND HEALTH

INTRODUCTION

This chapter analyses the main arguments around culture, ethnicity and racism, and how they relate to, and influence individual health and health policy. This study is about the health beliefs, lifestyle behaviours and health status of a minority ethnic group - the Greek Cypriots -; it is also about the ability of the health purchasers and health providers, to provide a culturally competent service to this ethnic group. In view of the virtual absence of epidemiological and demographic data, and any significant relevant literature about the Greek Cypriots living in Britain, I will attempt to use the literature which is available about other ethnic groups as well as drawing on material dealing with culture, ethnicity, race and inequalities in health. I do this for three main reasons:

⇒ Firstly, because there is a growing recognition that culture and ethnicity are crucially significant in both determining our health beliefs and behaviours and in guiding the purchasers and providers of health services.

⇒ Secondly, because minority ethnic groups, although very heterogeneous, both between groups and within groups, share the experiences of migration and racism or ethnicism.

⇒ Thirdly, because the study of, and reference to other groups may provide a deeper understanding of similarities and differences in terms of health values, beliefs, issues, needs, practices and behaviours, and in terms of how culture mediates for health.

Kelleher (1996) maintains that in Britain today there are two positions from which the analysis around patterns of ethnic health and health variations is conducted: the multi-culturalist position and the anti-racist position. The multi-culturalist position whilst not denying the existence of racism, attempts to emphasise both the existence and the validity of different cultural traditions amongst the ethnic groups in contemporary Britain. Ethnic group is not necessarily defined by colour. Through the promotion of tolerance and understanding of different cultural traditions, appropriate, relevant and culturally sensitive health care will be provided. It is argued that inevitably this will result in the improvement of health for all ethnic groups including that of the dominant ethnic group. The anti-racists on the other hand believe that attention to culture acts as a diversion from racism. Health inequalities can only be addressed if more political emphasis is placed on the forces that structure social relationships and determine access to power in society.

It is apparent that there exist ideological differences between the two positions. It also appears that the differences in the two positions may have been exacerbated by the problems surrounding the lack of clarity in the terms used by researchers and academics as they try to expand their knowledge and understanding around the health and illness of people from different minority ethnic groups. This view is supported by Bulmer (1986), McNaught (1987), Crowley and Simmons (1992), Anthias and Yuval-Davis (1992) who have suggested that the terms associated with minority ethnic groups such as *'culture'*, *'race'* and *'ethnicity'* are among the most elusive to define. Sheldon and Parker (1992) have identified a lack of consistency in terminology regarding ethnicity. In addition, McKenzie and Crowcroft (1994) have argued against using ethnicity as a variable in health research pointing out that this is most problematic in relation to second and third generation people who have had considerable contact with the English culture having been born and educated in England.

THE MULTI-CULTURAL EXPLANATION

As discussed already, there is little doubt that health is a complex, multi-faceted concept and that to be healthy, depends on many interrelated factors including biological, social, life style behaviours and the use of health services. The *'Health of the Nation'* (DoH 1992) requires health professionals to address the needs of the black and ethnic minority groups and to take positive steps to eliminate discrimination. In Chapter 1, it was pointed out that this requirement was emphasised in the Chief Medical Officer's report *'On the State of the Public Health 1991'*, which stated that people working within the health services should be aware of ethnic differences in disease patterns, and that they should consider how such differences can be met by the provision of appropriate services which embrace all aspects of health care and by modifying their approaches to take account of cultural variations. The opening paragraph of the document entitled: *'Variations in Health. What can the Department of Health and the NHS do?'* (DoH 1995) states the following:

> *For several decades now it has been well documented that across the developed world, there are variations in the extent of sickness and premature death between different groups within populations....Their variations in health status are associated with a range of often interacting factors: geography, socio-economic status, gender, environment, ethnicity, culture, and lifestyle. Variations persist even as health improves overall across the population.*
>
> (p5)

It has further been suggested that the current health care system fails many of its users, notably those who are not white or middle class (Torkington 1992). At best they are received with indifference but many are exposed to neglect and hostility to their culture (Torkington 1984). For some, problems are trivialised and the seriousness is not acknowledged whilst in other cases misdiagnosis occurs (McNaught 1987, Francis et al 1989). Thus the ability of health professions to deliver adequate and appropriate health care to Britain's multi-racial, multi-cultural population has recently been questioned (King's Fund 1990). This is consistent with

the Audit Commission's (1992) report that patients in general, receive little individualised care.

According to the multicultural approach this unsatisfactory position exists due to lack of knowledge and understanding of the various cultural traditions of ethnic groups. But what do we mean by culture and ethnicity, how does one achieve cultural understanding, and is the remedy as simple as it sounds?

Culture, according to Tylor (1871) is a complex whole which includes knowledge, belief, art, morals, law, custom and any other capabilities and habits acquired by people as members of society. Kessing's (1981) definition stresses the ideational aspect of culture; that is, cultures comprise of systems of shared ideas, systems of concepts, rules and meanings that underlie and are expressed in the ways in which humans live. Leininger (1991) also defines culture in similar ways:

> *Culture refers to the learned, shared, and transmitted values, beliefs, norms, and lifeways of a particular group that guides their thinking, decisions, and actions in patterned ways.*
>
> (p47)

It can thus be argued that culture is a set of guidelines (both explicit and implicit) which individuals inherit as members of a particular society, and which tells them how to view the world, how to experience it emotionally and how to behave in it in relation to other people, to supernatural forces or Gods, and to the natural environment. It also provides individuals with a way of transmitting these guidelines to the next generation by the use of symbols, language, arts and rituals. To some extent, culture can be seen as an inherited '*lens*', through which individuals perceive and understand the world that they inhabit, and learn how to live within it (Helman 1990). Growing up within any society is a form of enculturation where by the individual slowly acquires the cultural lens of that society. Without such a shared perception of the world both the cohesion and the continuity of any human group would be impossible (Helman 1990).

Pfeffer and Moynihan (1996) have suggested that culture and ethnicity are both woolly categories and that they seem to be used interchangeably. Fernando (1991) also believes that ethnicity is a term that lacks precision, and suggests that it alludes to the definition of both cultural and racial groups. The overriding feature of an ethnic group is the sense of belonging which individuals may have. This feeling may also be promoted by the way society at large perceives people. If certain persons are seen as belonging together for cultural or racial reasons, and are treated as such, a sense of being part of the group may develop. Thus cultural similarity, real or imagined may engender or even determine someone's ethnicity. Fernando, has stated that the concept of ethnicity has replaced to some degree both race and culture as a basis for defining groups of people in a multi-cultural, multi-racial societies. Most demographic and epidemiological data as well as many studies about health and lifestyles are based on ethnic groups.

Kavanagh and Kennedy (1992) and Dobson (1991) claim that we are all a product of our culture(s). Cultural background therefore has an important influence on many aspects of our lives including among others our beliefs, behaviours and attitudes to illness, pain and other forms of misfortunes, all of which may have important implications for health and health care. Dobson (1991) believes that our cultural upbringing can also make us ethnocentric to some degree; we see what our culture permits us to see, and we find it difficult to imagine life any other way. However, anthropologists such as Leach (1982) have pointed out that virtually all societies have more than one culture within their borders. Many of these groups will undergo some degree of acculturation, whereby they incorporate some of the cultural attributes of the larger society. Te Selle (1973) has suggested that in America, the dream of assimilation into a common culture has faded away; even among third, fourth or in some cases subsequent generation Americans, there is the widespread desire to know more about their heritage and culture. For this reason, Spector (1991) argues that it is mandatory for health professionals to be able to identify and to both accept and appreciate the cultural differences of their clients. She goes on to say that health professionals are socialised into the culture of their professions. They are taught a set of beliefs, practices, habits, norms and rituals all of which differs in varying degrees

from that of the individual's background. As they become more knowledgeable, they usually move farther and farther from their past belief systems and farther from the population at large in terms of its understanding and beliefs regarding health and illness. It is not uncommon to hear a patient saying *'I have no idea what the doctor said'*! When people of one belief system about health and illness encounter people with a different belief system, there occurs what is commonly referred to as *'breakdown in communications'*.

Leininger (1978, 1991, 1995), Spector (1991), and Dobson (1991) have argued that knowledge of cultural values are critical elements for nurses (and I would add other health care providers) if they are to provide appropriate, sensitive and reliable nursing (or health) care.

Smaje (1995) also supports the use of culture to study health; however, he warns that culture should not be used as a *'checklist'* but as an active social process linked to broader socioeconomic patterns. He refers to a number of studies from the developing North American literature which have begun to demonstrate the culturally-determined nature of the expression of illness, the resources mobilised to address it and the role of community and religious processes in promoting health (Kleinman 1987, Anderson et al 1989, LaVeist 1993, Levin 1994). In Britain, there have been fewer studies of this kind (Currer 1986, Donovan 1986, Fenton 1985). Smaje suggests that this may reflect the successful campaign by the anti-racists to invoke inhibitions about the notion of culture to any researcher interested in this field.

Leininger (1991) has reported on a number of studies which have used her culture care theory to investigate health beliefs and practices of a number of cultural groups such as the Mexican-Americans, the North-American Indians, the African-Americans, the Chinese-Americans, the Arab-Americans and many others. She also reported some findings of her study into the Greek-American culture which she conducted between 1984-88. She found that they prevented illnesses with proper exercise, using family folk practices, avoiding hospitals and eating *'good healthy'* Greek foods. They also showed concern about helping others to prevent illness and

that they involve their family and kin when they suffered serious illness. Rosenbaum (1991) found in her study of Greek Canadian widows that health meant a state of well being, an ability to perform daily role activities, and the avoidance of pain and illness. Lambert and Sevak (1996), in a study about perceptions of health and sources of ill health among Londoners of South Asian origin, reported similar findings. Their informants considered themselves to be healthy in terms of their ability to perform everyday functions without pain or difficulty. They however, expressed the view that being healthy was at least partly attributed to luck or chance. Blaxter and Paterson's (1982) study in Aberdeen, found that working class mothers did not define their children as ill even if they had abnormal physical symptoms provided they continued to walk around and play normally.

Helman (1990) has argued that the concept of culture has sometimes been misunderstood, or even misused. For example, cultures have never been homogeneous and therefore one should always avoid using generalisations in explaining peoples' beliefs and behaviours. One should therefore differentiate between the rules of a culture which govern how one should think and behave, and how people actually behave in real life. Generalisations can also be dangerous for they often lead to the development of stereotypes and then usually to cultural misunderstandings, prejudices, and also discrimination. Another reason why one should not generalise is that cultures are never static but are in constant process of adaptation and change.

An important point in understanding the role of culture is that it must always be seen in its particular context. It may therefore be impossible to isolate *'pure'* cultural beliefs and behaviour from the social and economic context in which they occur; for example people may act in a particular way not because it is their culture to do so but because they are simply too poor to do otherwise. Therefore in understanding health and illness it is important to avoid *'victim blaming'* - that is seeing the poor health of a population as the sole result of its culture- instead of looking also at the economic or social situations of the individual. Helman cites as an example the case of the Black Report (Townsend and Davidson, 1992) which showed that in the UK, health

could clearly be correlated with income. In the developing world too - whatever the local culture- poor health can usually be correlated with a low income, food, water, the sanitation that people can afford and so on. Thus, culture should never be considered in a vacuum but only as one component of a complex mix of influences on what people believe and how they live their lives.

A final misuse of the concept of culture -especially in medical care- is that its influence may be over-emphasised in interpreting how some people present their symptoms to health professionals. Symptoms or behaviour may be ascribed to the person's culture when they are really due to an underlying physical or mental disorder. This form of cultural essentialism which results in *'victim blaming'* has been vehemently criticised by the anti-racists lobby as we shall see in the following section.

I now return to the question I posed earlier: why have we not succeeded in providing health professionals the necessary cultural knowledge and understanding? The failure to promote and achieve culturally sensitive and appropriate care, has been partially blamed on professional education (Papadopoulos et al 1995, Leininger 1991, McGee 1992). Despite the fact that our understanding of health and illness has to be considered in terms of social and cultural determinants and not just biological factors, there is as yet little evidence to suggest that the education of health care professionals explores ethnic health in any meaningful and substantial way. Karmi (1992) suggested that recent attempts to integrate cultural knowledge in the curricula is long overdue as there is a widespread ignorance among health professionals at all levels about the culture and customs of the ethnic patients they deal with. Kushnick (1988) however has argued that well-meaning attempts to correct the deficiencies in knowledge and practice which have been reported within a multi-cultural framework can be counterproductive, since they may reinforce stereotypes of ethnic differences. It is not surprising that many health professionals and authors are strongly recommending that education and practice should move from this model to one which focuses on anti-racism (Ahmad 1993, Stubbs 1993, Papadopoulos and Alleyne 1995). Probably one of the most useful analyses on this topic is that of Rattansi (1992), who, whilst referring to the general education system, stated that there has been very little serious

thinking within multi-culturalism about how *'cultural understanding'* actually occurs, about its forms, mechanisms and limits.

THE ANTI-RACIST EXPLANATION

Minority ethnic groups face discrimination at many levels in society. Ahmad (1993), Pearson (1983), Donovan (1986) and Sheldon and Parker (1992) see cultural analysis as a diversion from the more important issue of racism. Racism may be seen as leading to disadvantage and inevitably to a higher rate of ill health (Townsend and Davidson 1992, Benzeval et al 1995). Brah (1992) arguing against a cultural analysis, has stated that this is largely based independently of other social experiences centred around class, gender, racism or sexuality, whilst Rattansi (1992) and Gilroy (1992) refer to the absence of these variables from the anti-racist analysis. This has led to the misconception that a group identified as culturally different is assumed to be internally homogeneous. Ahmad (1996) asserts that the rigid conception of culture emphasises cultural difference and helps to obscure the similarities between broadly defined cultural groups and the diversity within a cultural group. He goes on the say that discourses built around the concept of culture and cultural difference play an important part within the strategies of control of black people's lives through state systems of immigration control, education, professional ideologies and practices.

Goldberg (1993) argues that *'ethnic reduction'* -a repercussion of the multi-cultural position- first constructs all ethnic minorities as similar; they represent the *'other'*, but the *'other'* is then disaggregated as some are seen as making progress towards assimilation while others are blamed for failing to do so; in this way the culture of the group is pathologised. Thus the *'other'* points to elements of lifestyle which differ from what is assumed to be *'a normal'* English lifestyle (Pearson 1983, Donovan 1986, Ahmad 1993, Senior and Bhopal 1994 and Sashidharan and Francis 1993, Pfeffer and Moynihan 1996). Anti-racists, such as Ahmad (1993) have criticised the multi-culturalists, such as Qureshi (1989), Healy and Aslam (1990), and Rack (1990), for contributing to the establishment of a deterministic link between the culture of

minority ethnic groups and their morbidity, mortality and health behaviour; Ahmad (1993), characteristically, calls them *'cultural merchants'*.

Lambert and Sevak (1996) questioned the assumption made by multi-culturalists that *'culture differences'* in the UK population are predictably correlated with ethnic identification which affect health status, health related behaviour and receptivity to health information. They have argued that cultural difference may have limited value in explaining differentials in health status, health beliefs and health related behaviour in a multi-ethnic society. They cited Crawford (1977) who suggested that the emphasis placed on behavioural or *'lifestyle'* factors to explain the high incidence of chronic conditions results in *'blaming the victim'* while ignoring the social economic determinants of ill health. Ahmad (1996) has argued that the adherence to cultural explanations and its consequence of victim blaming, constructs minority communities as dangerous to their own health. As was discussed in the previous section, the multi-culturalist solution, is to equip health providers with cultural understanding while at the same time -according to the anti-racists- resocialising the culturally deviant through health education on the proper use of health services. Therefore, Mercer (1986) and Ahmad (1993, 1996) suggest that by pathologising culture we are making it the cause as well as the solution to inequalities in health and health care.

Anti-racism in the health service is not a strong or long tradition. Ahmad (1996) has suggested that the most important site of struggles in the area of *'race'* and health, are developments in the field of psychiatry, where Black Health Workers and Patients' Groups have made a significant impact and have succeeded in challenging psychiatric orthodoxies. He cites the work of Mercer (1986), Fernando (1991) and Sashidharan and Francis (1993), as well as the contribution of the African-Caribbean Mental Health Association and the Confederation of Indian Organisations.

The anti-racist health perspective is rooted in the history of black people, their experiences of colonisation, slavery and white domination. Indeed, the anti-racists would argue that the health status of black people cannot be understood outside this framework. Ahmad (1993) has stated that:

Racial inequalities in health are a part, and a consequence, of racial inequalities in substantive rights of citizenship. Equally, although the scope for reducing racial inequalities in health lies largely outside the NHS, the equity of health care provision is also of paramount importance. These struggles for equitable health and health care are essentially located in the wider struggles for equity and dignity which have been a part of black people's history.

(p.214)

A NEW UNIFIED APPROACH

Both the multi-cultural and the anti-racist explanations have been recently criticised. According to Kelleher (1996), the multi-culturalists have failed to emphasise adequately, this important point: that, in relation to understanding how people perceive health and illness, we must recognise that culture is a dynamic entity which changes to incorporate fresh ideas and perspectives, as people develop new ways of responding to their environment. On the other hand he argues that the anti-racists have tended to ignore the small scale developments and improvements in attitudes that have taken place.

McKenzie and Crowcroft (1994) have argued that the culturalist approach is problematic in relation to second and third generation people who have had considerable contact with the English culture, having been born and educated in England; they do however believe, that even though such individuals may come to regard their occupation more important in terms of their identity, they may still cling to what Nagel (1994) describes as '*symbolic ethnicity*'. Hall (1992) goes further and suggests that the postmodern subject has no fixed identity, as the fully unified, completed, secure and coherent identity, is a fantasy; the reality is that we often have contradictory identities within us, which we use in different situations.

Rattansi (1992) insists on the centrality of culture to understanding of race, though not in an essentialist version of either the multi-culturalist or the anti-racist movements. He argues that at one level, there are many differences and contradictions within the two movements, whilst at a deeper level there are fundamental similarities of conceptualisation and prescription between multi-culturalism and anti-racism which are flawed. Although both movements have made important contributions, his judgement is that their frameworks and policies share significant and disabling weaknesses. Both the multi-culturalist and the anti-racist approaches can result in cultural essentialism, for, whilst multi-culturalism often collapses analysis and prescription into some form of ethnic essentialism, in anti-racism, cultural essentialism emerges ironically enough partly out of the denial of ethnicity, as this is marginalised in preference of an exclusive focus on the *'black struggle'* issues.

According to Rattansi (1992), cultural essentialism at its core has begun to disintegrate. First, through an ethnic backlash from the British Asian and Afro-Caribbean communities which protested at the homogenisation of different histories, cultures, needs and aspirations, implied in the use of the singular category; second it has become increasingly clear that the category can marginalise the racialisation of other British minorities. Turkish and Greek Cypriots, for example, Jewish people and the Irish, have been unable to find a voice within a political and cultural space marked out as *'black'*. The category, in other words, functioned both to include and exclude; in so doing it tended not to engage with the variety of British racisms, although it was never intended to deny the existence of other racisms. The third challenge has come about as a range of *'black'* groups have begun to explore, construct and express identities not exhausted by the experience of, and struggle against racism; thus, we witness the emergence of what Hall (1992) has dubbed *'new ethnicities'* which represent complex intersections of sexuality, ethnicity and class, imaginatively constructed through representations which break decisively with a framework of positive and negative images. There is emerging a new cultural politics of difference which overlays the older ethnic differences. Gilroy (1992) reaches the same conclusion but through a different emphasis. In his view, an alternative framework is

emerging as a direct reaction to the moralistic excesses practised in the name of anti-racism. Not only has anti-racism evolved as a dictatorial form particularly in the context of local government, but it has also served to trivialise and isolate the struggles against other political antagonisms such as the contradictions of social and economic inequalities, the struggles of women and that of other marginalised groups. Yet, in Britain today, *'race'* cannot be understood or grasped, if it is falsely divorced from all these other political processes and power struggles.

Rattansi (1992) concludes that:

> *For these developments to be taken seriously, the multiculturalists will have to abandon their additive models of cultural pluralism and their continuing obsession with the old ethnicities. Antiracists, on the other hand, will have to move beyond their reductive conceptions of culture and their fear of cultural differences as simply a source of division and weakness in the struggle against racism. They need to acknowledge the political significance of questions of national culture and ethnic identity, and to grasp how these intersect with questions of 'race' and racism. They will also have to work through the consequences of other British racisms, especially towards Jewish people and the Irish, and the realignment of older Western-Islamic polarities in the context of the Rushdie scandal.*
>
> (p. 41)

The level and volume of discourse generated by the multi-culturalists, the anti-racists and those suggesting an alternative framework, strongly indicates the importance of addressing the quality of life of people from minority ethnic groups, and to understand not only the difficulties they face but also the contribution which they make, as they actively engage in many different ways, to establish themselves as equal citizens of this country. Citizenship, as Marshall (1964) explained, involves civil, political and social rights, all of which dictate against the subordination of one group of people to another. However, numerous studies in the field of health and social

welfare, have provided evidence which clearly shows that there exist many inequalities amongst citizens in Britain. One of the most significant studies which was reported in the Black Report (Townsend and Davidson, 1992), found that mortality rates for both men and women aged 35 years and over in occupational classes I and II had declined while those in classes IV and V showed little change or had deteriorated. It argued that social and economic factors, such as income, work, environment, education, housing, transport and lifestyles all affect health and all favour the better off.

Oliver and Heaton (1994) state that many groups, such as women, minority ethnic groups, homosexuals, people with disabilities, and those who suffer extreme poverty, feel that they are *'second class citizens'*. Naturally each of these groups is not exclusive of the other; if we take as an example the case of the minority ethnic groups, Kushnick (1988) claimed that because of the racism experienced by many people from minority ethnic groups, their position in terms of their economic circumstances, life chances and health, is likely to be similar, but also very likely that this would be worse than those of the majority white people living in Britain.

Oppenheim and Harker (1996) reports that unemployment (an important indicator of poverty and thus ill health) affects the most vulnerable people in society such as the unskilled, the disabled and people from minority ethnic groups. In 1994 the male unemployment rate for black people and other minority ethnic groups was 25%, over double the rate for white men which stood at 11%. The corresponding unemployment rates for women were 16% for black and minority ethnic women and only 7% for white women. For young people the unemployment rates were even greater; 37% of young men aged between 16 and 24 from black and other minority ethnic groups were unemployed compared to 18% of white men. For young women the figures were 27% and 12% respectively. Even with qualifications members of minority ethnic groups are still more likely to experience unemployment because of discrimination. A sizable proportion of people are living in poverty, working in low paid jobs. In 1994 the average hourly pay of all minority ethnic employees was 92% of that of white employees.

Oppenheim and Harker (1996) states that the persistence of high level of poverty for black and minority ethnic groups is due to a number of factors:

- ⇒ an immigration policy which has curtailed access to welfare services,
- ⇒ inequalities in the labour market are founded on deeply embedded discriminatory employment practices,
- ⇒ family patterns and the age structure of minority ethnic groups,
- ⇒ social security policies,
- ⇒ racism and discrimination in society as a whole.

In trying to analyse the determinants of health status, Benzeval et al (1992) modified Marmot et al's (1987) model of *'social forces -> lifestyle and exposure differences -> health differences'*. They disaggregated *'social forces'* into *'demographic and personal characteristics'* and *'material, social and physical deprivation'*, all of which have both a direct and indirect influence on health status through their impact on lifestyle. Using data from the *'Health and Lifestyle Survey'* which were reported on by Blaxter (1990), and which they further analysed, Benzeval et al (1992) discuss the implications of age, gender, ethnicity, poverty, unemployment, housing, the environment, education, social isolation, and social integration, on lifestyle and health status. They concluded that on the basis of their findings, the links between deprivation and poor health had been clearly demonstrated, and that they are certain that the distribution of health care resources both within London and in the rest of the country, ought to reflect the variations in social and economic circumstances in different areas. Whitehead (1995) suggests that four main policy levels seem to have emerged for tackling inequalities in health. These are: strengthening individuals, strengthening communities, improving access to essential facilities and services, and encouraging macroeconomic and cultural change. It may be argued that these initiatives are taking place, because of the consistent lobbying by the World Health Organisation (WHO) to persuade national and local governments to adopt the *'Health for All'* approach (WHO 1985), which has as its central aim to ensure greater social equity in health by adopting policies which:

a) reduce poverty at its widest sense,

b) secure the basic prerequisites for health for everybody -food, safe water, sanitation, decent housing and universal education, and

c) ensure that everybody has access to effective health care.

So, in terms of the first policy level referred to by Whitehead (1995) -individual strengthening policies- the aim is to build up a person's knowledge, motivation, competence and skills in order to enable him/her to alter his/her behaviour in relation to personal risk factors or to cope better with the stresses imposed by external health hazards. Strategies to promote personal empowerment, if applied, would be very relevant to members of minority ethnic groups, who as discussed earlier, are more likely to be the victims of discrimination and social exclusion. The second policy level focuses on how people in disadvantaged communities can join together for mutual support which could strengthen the whole community against health hazards. Although the word *'community'* is not clearly defined by Whitehead, reference is made to *'neighbourhoods'*. Social cohesion may well have geographical boundaries, but I would argue that this also occurs within communities which share elements of culture and identity -whether real or symbolic- such as in the case of the Greek Cypriot community of North London. The third policy level focuses on ensuring better access to what WHO call *'the prerequisites for health'* whilst the fourth policy level aims at reducing poverty and the wider adverse effects of inequality in society. According to Whitehead, interventions at policy level 1 and 2 have tended to treat the symptoms rather than the underlying cause of the problem. As these have been discrete experiments or short term projects, their overall impact on observed inequalities in health can only have been minimal. The challenge is to make the effective approaches more widespread and part of the mainstream services offered to people. In contrast, interventions at policy level 3 and 4 involve every section of the population and thus any improvements can be seen to have benefited everyone. However, she concludes that what has been missing in Britain so far, has been a strategic and co-ordinated approach which incorporates action across sectors and at various policy levels.

Coote (1992) puts forwards the idea that life chances are closely linked to the idea of individual empowerment as a requirement of citizenship, which entails being able to participate in society. This implies that all citizens must have equal access to services to ensure equal chances in life, thus the absence of unfair discrimination. It appears that the emerging new approach to addressing the health needs of black and ethnic minorities seems to be centred around the eradication of inequalities and the promotion of citizenship rights, responsibilities and involvement.

SUMMARY

This chapter examined the tensions and points of convergence of multi-culturalism and anti-racism, the two main positions which dominated the debate around ethnic health over the last three decades. The emerging new approach seems to combine the strengths of both perspectives by focusing both on culture and structure.

The next chapter reinforces the new approach to ethnic health by emphasising that effective planning for health care is a complex and multi-dimensional activity, which requires accurate demographic, epidemiologic and cultural data.

CHAPTER 6

THE NEED FOR A HEALTH STATUS PROFILE

INTRODUCTION

In Chapter 1, I suggested that NHS health care purchasers and providers have very little information about the Greek Cypriot community living in Britain. I also suggested that appropriate service developments and the provision of sensitive health care for the Greek Cypriot community, requires epidemiological and demographic data as well as cultural knowledge and relevant skills. This chapter, deals with the obligations and responsibilities of health purchasers and providers towards the Greek Cypriot community, and is structured using the five steps to understanding the dynamics of a population, put forward by Rawaf (1993): a) population profile, b) people's lifestyles, c) the environment, d) health problems, e) service utilisation.

POPULATION PROFILE

This represents the anatomy of the community based on accurate demographic data. Health Authorities rely heavily on census statistics to describe important characteristics of their populations such as size and type of ethnic communities, the gender and age of groups and the socio-economic status. However, in the case of the Greek Cypriots, the information is simply not available and there are no national plans to collect it in the future.

In April 1995, *'ethnic group'* became a mandatory field in the contract minimum data set for admitted patient care in England which covers in-patients and day case patients. This initiative acknowledges the fact that there is a growing concern that people with different racial and cultural backgrounds show different patterns of disease and have different health service needs. It is very disappointing that NHS ethnic monitoring is using the classification and coding of ethnic groups used in the 1991 Office of Populations Censuses and Surveys (OPCS) Census (White, Black

Caribbean, Black African, Black other, Indian, Pakistani, Bangladeshi, Chinese, Other Ethnic Group) not only because this approach will continue to neglect the health needs of large ethnic groups such as those of the Greek Cypriots, but also because these ethnic categories have been criticised as being meaningless and by their problematic nature, they present a form of cultural reductionism and ethnic essentialism (Pfeffer and Moynihan 1996 and Rattansi 1992).

Smaje (1995) suggests that data on various groups not included in the ethnic monitoring of the census and the NHS, must be collected at local level using a variety of means. In the case of the Greek Cypriot community, the evidence which was gathered during this study (see Chapter 9), suggests that interest of health purchasers and providers to obtain local data about them varied considerably. The relative lack of interest may be based on the relative invisibility of this community and the misconception that this community is successfully acculturated to their host community and therefore has identical health behaviours and needs. There are exceptions to this proposition the main one being the case of thalassaemia, which, as a biologically based condition continues to be acknowledged. This thesis will not deal with thalassaemia exactly because it is the only health issue which has been identified and as such associated with the Greek Cypriot community. Research into haemoglobinopathies (of which thalassaemia is one) has been and -to a lesser degree in recent years- is being carried out; specific services, such as ante-natal screening and counselling, as well as treatment for sufferers of thalassaemia major, is provided even though they are criticised from time to time for their variable quality. The case of thalassaemia is a good example to explain the colonisation of the health of minority ethnic groups by the dominant group. This being a biological condition, it is readily recognisable and firmly linked to the ethnicity of the sufferer, whilst the dominant societal group, represented by the government and those health professionals in most powerful positions, are seen as the benefactors of this minority ethnic group. The dominant group need not admit to or deal with discriminating social and health care structures which may precipitate or cause a multitude of other health problems, but merely respond to this '*ethnic*' pathology. Not only has thalassaemia successfully become a stereotypical characteristic of the Greek Cypriot

community by those outside it, but even Greek Cypriots have come to recount it as the major health problem of their community despite the fact that many of them have never met or know of anyone who suffers from it, something which clearly indicates the decline of this condition within the Greek Cypriot community. Notwithstanding the case of thalassaemia, the *'acculturation assumption'* referred to above, is problematic in three ways:

⇒ Firstly, it is wrong to regard this community's failure to bring their health concerns to the attention of the relevant authorities as an absence of a health agenda from this community;

⇒ Secondly, health purchasers and providers are required by the Department of Health to assess the needs of their local populations and thus failure to do so tantamounts to a failure to care (The NHS and Community Care Act 1990, The Health of the Nation 1992, Priorities and Planning for the NHS 1996/97).

⇒ Thirdly, acculturation is a gradual and complex process, the rate at which it occurs, is not merely related to time, but to other factors, some of which were discussed in Chapter 5.

I do, however, believe that there is also a need to challenge and change the current ethnic classification system. It is disconcerting to realise that even leading authors in the topic of ethnic health, are placing so much faith in the ethnic monitoring scheme commenced in 1995, occupying themselves on the needs of the ethnic groups which are included in the scheme without voicing their concerns about the many groups for which specific ethnic data will not be collected. Without data about such groups as the Greek Cypriots (especially in places where they form a substantial proportion of the population) Health Authority population profiles will be incomplete. Without the collection and monitoring of such data, it would be impossible to eliminate

discrimination and ensure equal access to appropriate services for the Greek Cypriot community.

PEOPLE'S LIFESTYLES

Lifestyles of different communities are varied and influenced by culture, religion, ethnic and socio-economic factors (Helman 1990, Blaxter 1990, Leininger 1991, Dobson 1991, Dahlgren and Whitehead 1991, Spector 1991, Calman 1992, Beattie 1993, Hopkins and Bhal 1993, Smaje 1995, Benzeval et al 1995, DoH 1995, Kelleher 1996). It is important to understand these influences on health and disease and thus people's perceptions and expectations of health services. A number of national studies such as the 1994 HEA's *"'Health and Lifestyles. Black minority ethnic groups in England'*, the *'Health Survey for England 1991* (White et al 1993), the *'Health Survey for England 1994* (Colhoun and Prescott-Clarke 1996), the King's Fund London Initiative *'Health Status of Londoners'* (Benzeval et al 1992), provide national yardsticks useful for local comparisons and target setting. But none of these studies provide any information about the lifestyles of the Greek Cypriots living in Britain mainly because these (and all other) national studies use the ethnic classification system which was referred to above. However, the origins of national studies, are often to be found in local, preliminary studies, carried out by interested individuals or small teams, which raise health issues of particular community groups and often steer and influence the debate around these concerns. It could therefore be argued that the dearth of such studies and/or debate about the Greek Cypriot community has a negative effect, as their health concerns fail to attract national attention. But why are such studies not being undertaken? I would argue that there are three main reasons:

- First, the lack of demographic and epidemiological data (a vicious circle phenomenon);

- Second, the relative absence of Greek Cypriots from the health professions (Papadopoulos and Tilki 1996). This does not imply that such studies should

only be undertaken by Greek Cypriots; I am, however, suggesting that if the Greek Cypriot community were better represented in these professions, it is possible that such individuals would be more sensitive to the need for more knowledge and understanding about the ethnic group which they belong to. There are many examples from other ethnic groups to support this position (Gelazis 1995, Ahmad et al 1991, Balarajan et al 1984, Bhopal 1988);

- A third reason may be the failure of this particular ethnic group to exert adequate pressure on those responsible for planning and providing health services, in order to have their community's health needs investigated and their problems (if any) addressed.

THE ENVIRONMENT

Poverty, deprivation and poor housing all influence the health of the population (Townsend and Davidson 1992, Townsend et al 1988, Dahlgren and Whitehead 1991, Benzeval et al 1992 and 1995, Wilkinson 1996). Planning for these requires a collaborative approach with other agencies particularly the Local Authorities. Intelligence on these topics can be shared. The OPCS census provides vast amounts of data which need to be supplemented by local surveys and qualitative studies particularly in the case of minority ethnic groups such as the Greek Cypriots, whose ethnic category does not form part of the classification system being used. It seems apparent that health service purchasers and providers must endeavour to compile environmental data about all their constituent groups. It is obvious from the data I presented in Chapter 3, which were drawn from the sector profiles of Enfield and Haringey Health Authority, as well as from my attempts to elicit further information through the survey of purchasers and providers (Chapter 9), that specific environmental data about the Greek Cypriot community do not exist; furthermore, no attempts have been made to obtain any. Again the question is why. To illustrate this point, I return to the issues related to housing which were raised in Chapter 3, and are also discussed in Chapter 8. House ownership is often associated with wealth. In the lifestyle survey which is reported in Chapter 8, 84% of the Greek Cypriots living

in the Enfield and Haringey area, who participated in the survey, were found to either own outright or be in the process of buying their homes. This is much higher than the percentage reported for the general public in that area which stood at 60%. However, as Anthias (1992) observed, the types of houses bought are more likely to be larger ones at the cheaper end of the market. In particular, first generation migrants tended to buy such dwellings near their places of work, often in the most deprived inner city areas. To cope with the mortgage payments they usually rent rooms, whilst themselves living in squalid conditions. As the time passed, some of the Greek Cypriot immigrants were able to sell their big houses and move into smaller ones in more affluent areas such as Enfield. However, the findings of my survey (Chapter 8) also seem to indicate that many households have low incomes. This, coupled with the fact that the first generation population is getting older, means that houses are hard to maintain. It is difficult to argue that living in substandard accommodation, with little disposable income, has no effects on health. I would therefore suggest that this apathy and lack of concern about the largest minority ethnic group in Enfield and Haringey, amounts to indirect discrimination or institutional racism. The NHS aims to judge its results using the criteria of *'equity'*, *'efficiency'* and *'responsiveness'*. Bahl (1993) has stated that lack of adequate information on ethnic minority populations has meant that fewer services have been planned in a sensitive and equitable manner.

HEALTH PROBLEMS

According to Rawaf (1993) factors which contribute to excessive deaths and ill health should be identified, using all the available data which are routinely collected and those which are to be found in published materials. However, like Smaje (1995), he too recommends that when data is not available, specific research programmes should be undertaken to rectify the deficiency. Health authorities will find the recent publication of the DoH (1995) on *'Variations in Health: What can the Department of Health and the NHS do?'*, useful when focusing on the health problems of minority ethnic groups. However, the data are mainly about mortality rates and there is very little on morbidity or disability. The document, does however emphasise the areas where variations may exist and reminds planners of the possible reasons and

implications of the existing inequalities of health whilst recommending the Dahlgren and Whitehead (1991) model of health as a useful framework to be used to structure health status profiles of populations. The model places the individual, with his/her unique characteristics of age, sex and hereditary factors in the core of understanding and planning for health. Individual lifestyles, social and community networks, living and working conditions (food, education, work environment, unemployment, water and sanitation, health care services, housing), are framed within a general socio-economic, cultural and environmental context. Rawaf (1993) has suggested that certain diseases, such as haemoglobinopathies (including thalassaemia), are found mainly in ethnic minority groups, whilst others, such as diabetes and coronary heart disease, are in excess of that found in the indigenous white population. Others, such as mental illness, may be seen as often reflecting racism and ethnic stereotypes. The assessment of health problems at individual and group level, are undertaken at varying degree of effectiveness and co-ordination by a number of health professionals. However, the channels through which local health practitioners can feed their assessment of health problems and needs into their local health care systems are not clear. The evidence which I collected from GPs, Health Visitors, District Nurses and Link Workers (Chapters 7 & 9), indicates that their views not only about the Greek Cypriots but in general, are not being fed into the needs assessment systems which were set up within Enfield and Haringey.

SERVICE UTILISATION

Barriers to service utilisation such as language, racial prejudice and insensitivity to socio-cultural needs have been identified as the major factors which contribute to ill health amongst individuals from minority ethnic groups (Hopkins and Bahl 1993, Ahmad 1993, The Scottish Office 1994, Smaje 1995, Askham et al 1995). Evidence on ethnic patterns of utilisation of services is based on a relatively small body of research (Balarajan et al 1991, Benzeval and Judge 1993, McCormick and Rosenbaum 1990). Rawaf (1993) asserts that ethnic monitoring will go a long way in identifying gaps in service utilisation. However, Smaje (1995) stressed that monitoring service utilisation through utilisation data alone is very problematic

because of the inadequacy of information and the disagreement regarding the methodology of collecting and analysing such data. As indicated elsewhere in this thesis, there are a number of problems related to the use of the current classification system, not only in terms of the ethnic groups it does not include, but also in terms of those which it does. For example, it is generally acknowledged that the term *'Asian'* is too broad to have real usefulness. From the methodological point of view, there are a range of other factors underlying the utilisation of services - in addition to the barriers identified above-, such as age, socioeconomic status, morbidity, the geographical distribution of health services, as well as knowledge of, and attitudes to health services. The Commission for Racial Equality (CRE) and Age Concern (1995) reported that one of the myths which prevail about minority ethnic groups is that the *'no use of service equals no need'*. They contend that any low take up of services is often due to the fact that people do not know about them, or they are not the right kind of services. Smaje (1995) argues that quantitative data collection and analysis, needs to be complemented by qualitative data, for a more meaningful interpretation of service utilisation.

Simply looking at the utilisation of a service without considering the quality received by members of various ethnic groups would inevitably only provide half the picture. For example, in a separate study on the primary health care needs of the Greek Cypriot women (Papadopoulos and Worrall 1996), much of the evidence illustrates the poor service that some GPs provide to these women, especially those from the first generation. Even if, ethnic monitoring data were collected for the Greek Cypriots, assessing the frequency of use in this case -although ethnic monitoring is currently only a requirement for in-patient services- would not help explain why the Greek Cypriot women use the GP services more or less frequently than other ethnic groups or indeed the majority group. Owen (1994) reported that the geographical location of many ethnic groups in predominantly urban areas means that they are more likely to use single-handed, inner-city and non-fundholding general practices with fewer resources. Poor quality may result both in lower levels of utilisation but paradoxically also in higher levels, as individuals will visit more frequently as a direct result of poor intervention and advice in the first place.

Despite the difficulties, monitoring service utilisation is required in the hope that accessible health services can be provided based on the actual needs of the population. Mohammed (1993) argued that the NHS reforms of the 1980's and early 1990's promoted the value of user involvement in the monitoring processes, as well as community consultations in the development of services. Brotchie and Wann (1993) suggested the need for empowering lay people through training so that they can fully contribute in these processes whilst the Department of Health (1994a, b) admitted that black and minority ethnic users and carers were the least likely to be involved and that new ways need to be explored -including the provision of skills and confidence training- in order to encourage their involvement. Clearly, both national and local data are important for effective and appropriate planning. Enfield and Haringey Health Authority, at the time of this investigation, had established a Health and Race committee with membership from umbrella organisations of the voluntary sector. Whilst appreciating that not all community groups can sit on this type of committee, and whilst the effectiveness of such a committee often depends on the quality of leadership and membership as well as the genuineness of the Health Authority to support and act on the recommendations of this committee, I would question the ability of such a committee to deal with the enormity of specific issues or even general principles, which relate to each community group particularly those (as is the case of the Greek Cypriots) who are not directly represented. In addition the Health Authority should, through service specifications and contracts, not only outline the volume of the services required but also the dimensions of quality for the services such as acceptability, equity, effectiveness, efficiency, appropriateness and humanity. Perhaps also, they should contextualise elements of contracts so that specific information about X or Y ethnic group could be obtained, thus utilising the opportunity afforded by the contractual processes, to monitor utilisation of services and identification of need/gaps.

SUMMARY

This chapter examined the rationale for the construction of a health status profile for the Greek Cypriot community living in Enfield and Haringey. Such a profile should

contain demographic, epidemiological, socio-economic and cultural data. It was argued that the availability of such a profile will enable health professionals to plan and provide appropriate and acceptable services.

The next chapter presents and discusses the findings derived from numerous group and individual interviews around the health beliefs, lifestyle behaviours and health needs of this community group.

CHAPTER 7

AN EXPLORATION OF HEALTH BELIEFS, LIFESTYLE BEHAVIOURS, AND HEALTH NEEDS OF THE GREEK CYPRIOTS

INTRODUCTION

In Chapters 1 and 3, 5 and 6, it is argued that the reforms of the National Health Service which took place in the late 1980s and early 1990s, highlighted the need to examine the health needs of minority ethnic groups and to improve the services provided to them (DoH 1989, 1990, 1991, 1992, 1993).

This chapter is an exploration of the health beliefs, lifestyle behaviours and perceived health needs of the Greek Cypriot community from three different perspectives. The first section provides the views of ordinary Greek and Greek Cypriot people whilst the second section is an account of the views of a number of key Greek Cypriots (see Chapter 2) who, due the nature of their work (please see table 2.1 for details) have regular contact with large numbers of their community. Section three, discusses the views of a number of Greek Cypriots who are working in the health field.

GROUP AND INDIVIDUAL INTERVIEWS

During 1993 and the early parts of 1994, I conducted '*small group*' interviews with nineteen (n=19) members of a Cypriot elderly and disabled club; of them three (n=3) were men and sixteen (n=16) were women. These informants were all first generation Greek Cypriots. I also interviewed two groups of twenty five (n=25, total n=50) women at a Greek Cypriot womens' club. A small number of them were second generation Greek Cypriots, but the vast majority were of first generation. In addition, I carried out ten (n=10: males =3 and females=7) in-depth individual interviews in individuals' own homes. Four of the female (n=4) and two of the male (n=2)

informants were of first generation, whilst three female (n=3) and one male (n=1) were second generation. All interviews were conducted in Greek and I kept detailed notes which I transcribed in English immediately after the interview. The interviews were semi-structured. I had identified a number of areas which I wanted to explore and allowed this exploration to develop in an informal way. Informants were asked to talk about their health and illness beliefs and whether they thought being a Greek Cypriot affected the way they viewed health, illness, the National Health Service and the care they received from health professionals. They were also asked to talk about the state of their health and to make suggestions about health services most needed by the Greek Cypriot community. Through the group interviews, a number of themes emerged which were explored further, verified, confirmed or modified during the in-depth individual interviews. All my informants appeared keen to talk, and they provided me with a rich source of material, some of which were peripheral to my immediate interest, but knowing the Greek culture as I do, I was prepared to spend more time with them, to exchange views on some issues. My informants saw me as someone who knew about hospitals, doctors, diseases and treatments. I have discussed these points in more detail in chapter 3, section 3.2 (ethical considerations).

The radio programme

Early in 1993, the London Greek Radio (LGR) agreed with my suggestion to devote one of its programmes called *'Your Own Opinion'*, on the views of the Greek community about the changes which were taking place within the NHS. The programme is a weekly 'phone in' lasting 1 hour and 30 minutes interspersed with music. The programme producer and I did not want the public to be ringing asking for advice about their own health problems, so we decided to focus the programme on their views about the profound changes in the NHS which were taking place at the time, primarily as a result of the NHS and Community Care Act 1990, the changes into Trust status for service providers, the Health of the Nation Strategy (1992), the Patient Charter and so on. Unfortunately, a power cut reduced the effectiveness of this approach and it was not possible to repeat the programme. My notes from five men (n=5) and six women (n=6) (two women spoke in fluent English, which may

indicate that they were second generation Greek Cypriots), were included with the analysis of the interviews with the Greek Cypriot public.

Analysis and identification of themes

The transcripts of the interviews were analysed using the approach described in Chapter 2. As can be deduced from the previous sections in this chapter, there is a gender and generation bias in the data which needs to be borne in mind throughout this section which provides the analysis of these interviews. Six major themes emerged each consisting of a number of elements. These are listed below, and they are then discussed in detail.

1. Health is...:Beliefs about health

Theme elements:
- 'Nous' and health
- Keeping healthy
- Health and age
- Work and health
- God looks after me

2. Illness is caused by...:Beliefs about the causation of ill health

Theme elements:
- Stress and illness
- Poverty and ill health
- Eating too much, working too hard
- Illness is self inflicted; taking chances
- Medical conditions
- Use of traditional remedies (*'practica'*)

3. Family as a health resource

Theme elements:
- My son comes with me to the hospital
- I discuss my problems with my mum
- My family visited me in hospital and gave me 'tharos'
- Sharing problems and good times

4. Family as a cause of health problems

Theme elements: It started when I became pregnant
My husband left me and the children
I am worried about my children
Blaming self

5. Beliefs about the National Health Service

Theme elements: Examples of good care
Inappropriate treatment
Lying to get treatment
Changes in the NHS
The experience of discrimination
Use of private medicine

6. What is needed is...:Purchasing and providing care

Theme elements: Greeks are different
Health services for GC community
The need for health care staff who come from the Greek community
Need for information

Findings and discussion

Theme 1. Health is...:Beliefs about health

Theme elements: 'Nous' and health
Keeping healthy
Health and age
Work and health
God looks after me

A number of health beliefs were expressed by the participants. Many believed that health very much depends on the individual's brain (**nous**), or mental attitude. Greek Cypriots expressed their belief that the brain controls our attitudes and behaviours.

This belief indicates the existence of an autonomous person who can make decisions and control his/her life. The emphasis on the 'nous' also indicates the power of positive thinking and its association with health. One of the participants expressed it in this way: ***"If you don't think about illnesses you stay healthy longer"***. Participants also held the view that if a positive, content attitude or predisposition contributes to health, the reverse also applies, in that being healthy means being happy. Some of the informants related health with an ability to solve one's problems. This was contrasted with the expressed view that ***"when you are ill you cannot deal with even the small day-to-day problems"***.

Keeping healthy through eating a healthy diet, walking, going to work, and visiting friends, were considered important. Some thought that the Greek diet was healthy whilst others disagreed, citing barbecues and other rich traditional foods as harmful. One participant defined being healthy as: ***"Eating what you want, be 'zoiros' (lively), be able to do what you want without suffering and be able to relax and sleep"***. Some thought that the Greek Cypriots do not know how to, or even when they do, they do not look after themselves.

Some of the participants associated health with age. One 59 year old woman said: ***"Health is strength. When I was younger I could do all the things I had to do like working, looking after the family without thinking about my aches and pains, I was stronger then. I would not think twice about going up and down the stairs 10 or 20 times. Now if I go once, I think about it the second time. I expect to get tired and breathless"***.

One of the most frequently used explanation of health was the ability to go to work, to do the housework and to perform one's social roles. ***"I would go mad if I did not work"*** said a 60 year old man, whilst a 53 year old woman said that ***"the most important factor for good health is work. When a person goes to work, he or she has something to occupy the mind. When the person does not think about him/herself and his/her problems, then s/he is happy for a few hours; this gives a person strength"***. Another informant suggested that a person is healthy even though

s/he may be suffering from an illness, if , when all the symptoms are controlled, s/he has no pain and is able to perform her or his social roles, ie, look after the family, or provide for the family and so on.

The spiritual dimension to health was also mentioned. ***"God is looking after me"*** was an expression often used. This belief was identified both as positive and negative. In a positive sense, this gave individuals spiritual strength and led them to healthy behaviours. In a negative sense, the belief that God will look after us almost encourages Greek people to take too many chances with their health. One 25 year old woman observed that ***"the Greek Cypriots on the whole, know what is good and what is bad for their health but they are too optimistic in their outlook, often taking too many chances, always hoping that they will not be the unlucky ones to become ill, often believing that God will protect them".***

Theme 2. Illness is caused by...:Beliefs about the causation of ill health

Theme elements:
- Stress and illness
- Poverty and ill health
- Eating too much, working too hard
- Illness is self inflicted; taking chances
- Medical conditions
- Use of traditional remedies ('practica')

There is little doubt that the Greek Cypriots regard stress as the number one cause of ill health. This is reflected in the existence of such a rich vocabulary to express the notion of stress. My transcripts revealed twelve different ways which are worth noting here. **'Stenochoria'** is a word often used. This literally means **'narrow space'**, thus it describes the feeling of being squeezed in a narrow space and finding it difficult to escape from it which would give rise to panic, breathlessness, anxiety and all the symptoms which, increased levels of adrenaline would cause. Some informants referred to it as **'varos sto stethos'** which means having a weight on one's chest. **'Melancholia'** is used to describe the sadness which accompanies a stressful episode. This literally translates as black bile; it is interesting to note that early theories of

mental illness used the concepts of body fluids such as bile to explain a persons mental predisposition. The concept **'anghos'** which is often used, probably originates from the word **'anghone'** which means a noose, thus it describes a choking feeling; anguish would be a similar English word. **'Marazi'** describes a feeling of depression and sadness; the nearest concept used in medicine is **'marasmos'** which describes wasting or withering of the body due to physical or mental illness. Another two expressions used are **'vassana' and 'skepses'.** The first describes the problems, trials, ordeals of life which cause pain, distress and torture the mind. Skepses on the other hand is the mental preoccupation with all these problems. The word **'psychosynthesis'** was often used to denote the person's mental and psychological abilities to deal with problems. It was proposed that those with weak **'psychosynthesis'** are more prone to ill health. This explanation of illness was associated with another expression, that of **'tharos',** which means courage. Having courage indicates a strong personality, which in turns gives the person the ability to cope better with life's events good and bad, all of which could affect health. **'Lebe'** (sadness) and **'hara'** (happiness) can both cause illness according to my informants. The case for **'lebe'** has been alluded to above, but one may wonder how 'hara' can cause illness. Extreme happiness, according to my informants, can be just as stressful as extreme sadness; both can cause shock. One of my informants claimed that one of his relatives became a diabetic after the shock and happiness of seeing her son unexpectedly after many years. (This explanation is not entirely without foundation as medical textbooks associate the onset of some diseases with shock). Finally, the word **'monaxia'** was used to describe stress. The word means being alone (monos = one). Loneliness is seen as a major cause of illness. It is associated with all the previous discussion.

The informants made the link between poverty and ill health. One man expressed it thus: ***"If you are poor you have problems; you argue with your wife, you cannot afford to see the doctor of your choice when you are ill, like the rich people do".*** A man who participated in the radio programme said, ***"Nowadays, people do not use some of the services because they think they might have to pay, and some cannot***

afford to do that". A woman told me how her arthritis gets worse in the winter because she cannot afford more than four hours of heating per day.

Most of the informants expressed the view that the Greek Cypriots eat too much and probably the wrong foods, such as too much meat. They also agreed that Greek Cypriots work too hard. Here we see that work, - although previously perceived as one of the main factors for maintaining health- is perceived as a contributor to ill health. One woman explained: *"Greek Cypriots work too hard. This puts a stress on their health and on their family relationships...they neglect their children; it's not that they don't love them, but they hardly see them...they are showing their love by buying them everything they ask instead of spending time with them...that is why some young people are growing up very confused which is not healthy".* However, unemployment was also referred to by a few, as a cause of ill health.

Eating too much, smoking excessively, working too hard, no time for exercise, living dangerously, were all associated with self inflicted harmful behaviour and neglect. One woman articulated this phenomenon in this way: *"There seems to be a mentality which compels our community to want instant gratification, instant fixes for everything...instead of looking after themselves, they run around searching for the best cure when they are ill".* Some informants expressed the view that the Greek community has become very materialistic, regarding the acquisition of wealth as more important than health, whilst believing that when they are ill they can buy the best cures.

The informants reported to be suffering from a whole range of medical conditions which I will not list. Many of them believed that *"Our health problems are not different because we are Greek. We have the same problems as everyone else".* Although one person claimed that *"...our problems are related to language, thalassaemia and Greek diet".*

The use of '**practica**' (traditional remedies) was one of the ways some, particularly the first generation informants, are using to treat themselves when ill. Herbal teas

such as, mint (for indigestion), chamomile (to calm the nerves), tea made from stems of cherries (for stomach pains), aniseed (for digestion), are used. A man told me that a few years previously he suffered from alopecia and all the treatments his doctor gave him did not cure it. When he went to Cyprus, an old barber applied a liquid which he had made and this immediately cured his alopecia. An elderly lady told me that she still uses **'thermo'** to treat vaginal or urinary infections. This remedy, was a popular vaginal douche following the birth of a child in Cyprus. It is made by boiling in water, eucalyptus leaves together with leaves or flowers from a lemon tree and rosemary. For sore throats, some informants explained that they gargle with warm water and salt. For arthritis or muscular pains and inflammation, soak a piece of cloth in **'zivania'** and apply to the painful part. (Zivania, is a pure alcohol drink, which is made with the pips and skins of grapes after they have been squeezed to make wine). Alternatively, mix pepper and methylated spirit and apply in the same way. For bruises, squash an onion by hitting it with something heavy, then pour over it salt and apply to the bruise.

Theme 3. Family as a health resource

Theme elements: My son comes with me to the hospital
I discuss my problems with my mum
My family visited me in hospital and gave me 'tharos'
Sharing problems and good times

The family, appears to be the centre of the informants' social worlds. It defines their roles, it is a source of moral and practical codes of behaviour, it is associated with health and illness, stress and happiness, the most important of all institutions. Most of the first generation informants could speak little English. The elderly, also had mobility problems. They all stated that when they had to go to the doctor or the hospital they were accompanied by a son or a daughter or even a grandchild in some cases. Even the 53 year old woman who had to attend a mobile clinic for a mammograph remarked ***"...I would never have found the place if my son had not come with me"***.

Having a family means having someone to share one's problems or to get advice. A divorced woman in her thirties, who is bringing up three teenage daughters on her own admitted having many health problems and finding it difficult to cope with the demands her daughters make sometimes. She said : ***"I don't know what I would have done if I didn't have my mum to help me and advise me".*** However, the maternal influence was seen as a negative act by one of the informants who said that mothers have an enormous influence on their daughters when it comes to health. She believed that even though many had been born and educated in this country and have no language problems, they are still ignorant about the importance of smear tests, breast examinations, good diet, and are misinformed about health issues such as AIDS. When they are confronted with the facts they respond ***"...but my mum told me so".***

Hospital nurses often complain that Greek people have too many visitors. Some of my informants, reflected on their hospital experiences, commenting how important the visits from family members were to them. ***"My family gave me tharos....",*** meaning encouragement to face the illness or treatment. And whilst visiting the ill person at home or in hospital is seen as providing a source of strength, the opposite appears to apply. Some informants said they would be upset and worried if they were not visited and this ***"cannot be good for you".***

Theme 4. Family as a cause of health problems

Theme elements: It started when I became pregnant
My husband left me and the children
I am worried about my children
Blaming self

The family is also a source of stress and therefore a contributor of ill health. Some of the informants associated their poor health with stressful family incidences. One woman traced her illness to her pregnancy, whilst a man reported that he started smoking heavily to relieve the stress caused by family problems. He is now suffering with chronic bronchitis but continues to smoke.

Two of the women informants were divorced, whilst two further reported that their daughters were divorced. One of the women reported that before he left her, her husband used to beat her up. ***"He was a gambler and a very mean man"***. After the divorce he refused to give her any maintenance and she was forced to work long hours as a machinist, to bring the children up. She now suffers with arthritis in her hands and shoulders and has had surgery on both of her wrists.

Worrying about their children is a constant source of anxiety particularly for women. A woman recalled how she became depressed and had a nervous breakdown after her seventeen year old daughter left home to live with friends. Although the daughter has since returned home, the informant reported that they constantly argue because in her view her daughter goes out a lot, which apart from all the dangers, she is jeopardising her chances of finding a good husband because ***"men like to marry domesticated girls"***. According to another woman many mothers are nervous wrecks because they worry too much about their children: ***"They worry in case they are attacked in the street, they worry if the bus is late...."***

Informants, particularly the women, blamed themselves for some of the misfortunes of the family. A woman said ***"...If I had not left my husband may be I would not be in the position I am today. I have to be strong for the sake of the children but lately I feel so drained, I feel I cannot go on like this"***. A man who has a twelve year old son who is mentally and physically handicapped, admitted that he could no longer cope with the child and wished he was admitted in a special unit. He said that he often quarrelled with his wife and felt guilty for rejecting the child and putting pressure on his wife.

Theme 5. Beliefs about the National Health Service

Theme elements: Examples of good care
Inappropriate treatment
Lying to get treatment
Changes in the NHS
The experience of discrimination

Use of private medicine

Many informants reported to be generally satisfied with the care they had received, particularly in hospital. One woman who took part in the radio phone-in reported to have had several operations following a horrific traffic accident. She said ***"...doctors were so good, they work so hard, and we Greeks take things for granted; we do not help our doctors; we must make allowances for the doctors especially the casualty doctors, the pressures they have to take and they have to put up with...."***. Another woman stated that although she is happy with the care she receives she never sees the same doctor twice. Two people reported that they were registered with GPs in different parts of London, and although they knew they would not receive home visits if they needed them, they preferred to stay with their GPs as they were happy with them. Praise was also given to the hospital interpreters by those who had used them. One person said ***"...there are times when you do not want to involve your family as translators"***.

Despite the high levels of satisfaction, many informants gave examples of what they considered inappropriate care. A woman described how her daughter, after suffering with fibroids for years, was taken to the A&E haemorrhaging. She subsequently had a D&C (Dilation and Curettage) and was sent home where she continued to bleed. The woman's husband had to argue with the GP to refer her to a hospital specialist who offered her a hysterectomy. Another woman described how some years ago she had a nasal sinus operation; she subsequently suffered with facial pain for a long time but described her GP as dismissive. She then saw a private doctor who took an X-ray and discovered that a needle had been left in her cheek. Another woman described how her non-English speaking father in-law lost his leg because the GP did not bother to examine his foot after visiting him several times in pain. One of her friends told her ***"...go down on your knees and ask him to send him to hospital for a check"***. This she duly did and the GP did exactly that. The patient was diagnosed as having gangrene and mild diabetes and had his leg amputated. They were many other examples of dismissive, stereotypical and insensitive care by doctors and nurses which I will not catalogue here. However one last example is very appropriate. A

woman was admitted in hospital for an operation. When she came round from the anaesthetic, she found that the patient in the next bed was a man. She was so horrified and worried in case she had to use the bed pan or uncovered herself whilst sleeping, that she discharged herself as soon as she could; ***"...I cannot see how anyone could think this is a good system".***

It was rather worrying to find that some of the informants reported that they had to lie in order to get treated. An elderly man reported that he was admitted to hospital for an operation. He said: ***"I told the hospital staff I had no children because I was afraid they would not help me and care for me and they would put all the burden on my children".*** A woman reported that she had suffered from stomach upsets but her GP ignored her complaints, telling her it was due to her nerves. She consulted a doctor at Harley Street, who prescribed some very effective tablets. She subsequently went back to her GP but was frightened to admit that she had seen another doctor. She told him instead that her friend was having these particular tablets and that they were very good and would he prescribe them. In the event he did not, but she had found another way to obtain these tablets without paying a private doctor; a relative sends them to her from Cyprus!

Most of the informants claimed not to understand the changes which were taking place in the NHS. For example, of the eleven people who took part in the radio phone-in only one man and two women (one of whom worked in the NHS) knew about the patients' charter. They had not heard of the Health of the Nation, they could not quite understand why the hospital were now becoming Trusts, or how community care was being reformed. But they did understand issues which affected them or of which they had some first hand experiences. There was unanimous agreement that the government was wrong to close hospitals. Most of their judgements about the NHS were very hospital based. For example, ten out of the eleven people who took part in the radio phone-in offered criticisms with reference to a hospital experience. They were also critical of long waiting times, which they blamed on financial cuts. A woman stated that ***"I am not informed about all these changes because I am too busy to listen to the radio or read the papers but what I***

know is, that when I had stomach problems recently, I went to see the doctor and waited for hours; so I got a taxi and went to the emergency department and solved my problem". However, a man reported that when he took his grandchild to the A&E they had to wait for five hours and when the child was being sick there was no one there to help them. His view is that hospitals are very short of staff, which is also due to financial cuts. Many referred to very long waiting times before getting an appointment to see a specialist. A man suggested that ***"...on paper the NHS looks that is improving but in reality it is getting worse than it used to be, due to lack of money".*** A woman argued that community care was failing the mentally ill and referred to an incident when a patient was discharged into the community due to the closure of the psychiatric hospital, with terrible consequences, as the patient apparently attacked a person in the underground and pushed him in front of a passing train.

Despite their bad experiences with the NHS, most of the informants believed that health professionals or the system was not discriminating against them as Greek Cypriots. However one informant suggested that discrimination does take place particularly when the carer -usually from the indigenous population- is under pressure or when there are competing interests. As an example, the informant described how, on visiting a relative at the hospital one day, he overheard two nurses who were caring for a patient in the next bed to say: ***"Bloody Greeks, they are so noisy".***

Many examples of using private medicine were cited. The reasons for these were due to lack of confidence in their own doctor either because s/he is not taking them seriously, or because they are afraid to discuss their problem, or because they are not satisfied with the treatment they are getting from their GP. None of the informants I interviewed reported to belong to a private medical scheme, so they paid directly for the services of the doctor even though clearly, some of them could not afford it.

Theme 6. What is needed is...:Purchasing and providing care

Theme elements: Greeks are different

Health services for GC community

The need for health care staff who come from the Greek community

Need for information

Many of the informants, as mentioned earlier, did not think that health needs of the Greek Cypriots are very different from anyone else's. However, some did, and this is reflected in the many suggestions which they offered when asked whether there were any health services needed by their community. Many expressed the difference in terms of their *'Greekness'* which, to a small degree made a difference to the illness that a person may suffer (such as thalassaemia), but which made a significant difference in the way health and illness are perceived and responded to. *'Greekness'* was explained as the psyche of a Greek person of whatever generation, which although it does not exist to the same level in all people, it nevertheless exist at different levels or variations in all those who define their ethnic group as *'Greek'* or *'Greek Cypriot'*. According to my informants the elements of *'Greekness'* are: Speaking or understanding Greek; eating Greek food; being a Greek Orthodox and going to Greek church even if it is only for major life events such as marriages, baptisms, deaths; listening to the Greek radio or Greek music; probably having attended Greek school, thus being able to read or write Greek; having Greek friends; feeling more at ease with another Greek Cypriot person; going to Cyprus or Greece for holidays. A young, second generation Greek Cypriot woman very poignantly stated: ***"When I am asked where I come from I always say I am a Greek Cypriot born in England. I cannot deny this, and if people feel the need to ask this question, it is obvious that I must either look different or behave differently or else they wouldn't have asked. But I am proud to be a Greek Cypriot...."*** This *'Greekness'* is what comes to the fore particularly when the Greek Cypriot person is not well. Another of my informants stated ***"... they will seek out their Greek connections, they will reach for another Greek person when they are ill"***.

A number of suggestions were made regarding the health services needed by the Greek Cypriot community. Many informants were particularly concerned about the growing number of elderly with little command of the English language needing care.

Nursing homes or old peoples' homes must be either exclusively provided for the Greek Cypriot elderly, or have Greek speaking carers and attendants. Even when they are able to live in their own homes elderly people need opportunities to socialise with other Greek speaking people and to gain information in Greek. If they have mobility problems transport should be provided to take them to day centres or clubs. Meaningful social activities are considered most important for health and welfare. They reduce isolation, and loneliness which as discussed earlier, is considered by many to be a cause of stress and therefore ill health.

Another recommendation made by several informants was the need to convince Greek Cypriots to look after themselves. The need to change the mentality that *'it would not happen to them'* and begin to value prevention more than they currently do, was identified. It was suggested that one way to achieve this would be through the provision of information about health topics and services, not only leaflets in Greek and English, but also through the Greek newspaper (which has an English section) and Greek Radio which broadcasts some programmes in English, specifically aimed at second and third generation Greek and Greek Cypriot people. Many informants highlighted the need for a womens' group or club for those women living in and around Enfield, where they could gain and exchange information as well as support one another. It was recognised that both elderly but also younger women of school age children could be isolated. With divorce, seemingly on the increase amongst the Greek Cypriot community, some women are facing a multitude of problems with little or no support. A small number of them have no family living nearby and no friends. As one woman explained ***"we sometimes do not need to see the doctor or the nurse, but need to get some advice ('parangelia') from another woman who understands our problems, who shares our culture...."*** It was also suggested that some women are stuck at home, *'machining'* and looking after the children often with no support from their husbands, who may find a friendly visit and the chance to talk to someone very therapeutic. It was pointed out that although the family is a source of help, it was also a source of distress, and the women would value talking to a non-family member.

Another suggestion was the need for more members of the Greek community to enter the health and caring professions. Many informants suggested that they would prefer to see a Greek Cypriot doctor because s/he would understand them better. People expressed this as a cultural bond, an empathetic understanding which was considered desirable by most informants whether they spoke English or not. One man told me, ***"...there are things you do not admit to an English doctor as he would not understand..he may think we are backward peasants"***. However when confronted by the fact that only a minute number of Greek Cypriots enter the nursing or midwifery professions, most of them replied that ***"one needs to have the stomach to be a nurse"***. Although they all admired the nurses and would preferred to be nursed by someone who was Greek/Greek Cypriot, they invariably replied that they did not encourage their children to enter these professions as they considered them to be dirty and low paid. They suggested that Greek Cypriot parents consider it inappropriate for young girls to be washing and cleaning particularly men. Their dream for their children is that they follow a career which would allow them to dress smartly and which would be an *'office'* type of job. In their view the only high status occupation out of all the possible caring professions, is medicine.

The need for information has been alluded to throughout this analysis. Chapter 9 of this thesis suggests that health purchasers and providers are failing to address the information needs of this community. It is true that some information is produced in Greek, but people are not accessing it. Some of the problems which have been reported by my informants, could have been resolved if people had access to the information in a meaningful way. Information would not only help improve the health of the Greek Cypriot community and prevent illness; it will also help those providing the services; many of my informants indicated that if they had information which helped them to understand why for example hospitals or hospital departments are being closed down (something which they were all aware and concerned about), perhaps they could be more sympathetic to the changes. Further still, my informants wondered why the Greek Cypriot community had not been consulted or involved in the decision making processes.

INTERVIEWS WITH 'COMMUNITY LEADERS'

Four men and two women were interviewed. All were chosen because they held key positions and had worked with, and for, the community for many years. They were considered to have a broad range of experiences and detailed knowledge about the Greek Cypriot community. The purpose for the interviews was to check out and note whether people of influence in the Greek Cypriot community shared the same views on the issues under investigation, with those members of the Greek Cypriot public whom I had previously interviewed. I also wanted to give them an opportunity to add new perspectives to the existing data and if possible, explore with them the health issues from a *'cultural lens'*. As their views generally confirmed the views expressed by the Greek public (discussed above), I will concentrate in this section in expanding on the links between the Greek Cypriot culture and health, illness and lifestyles. The analysis is organised under the following framework:

Theme 1: Culture and the origins of healthy and unhealthy behaviours and lifestyles

Theme elements: The effects of migration
Feeling inferior
Religion and health

Theme 2: Culture and health

Theme elements: Looking after yourself
The use of *'yiatrosophia'*

Theme 3: Culture and ill health

Theme elements: Mental health
The use of drugs
Ill health within the family

Theme 4: Culture and the need for health services

Theme elements: The need for health promotion
The needs of the elderly
Mental illness

Training for health professionals

Need for more Greek Cypriot health professionals

Findings and discussion

Theme 1: Culture and the origins of healthy and unhealthy behaviours and lifestyles

Theme elements: The effects of migration

Feeling inferior

Religion and health

The effects of migration was not discussed in detail during the interviews with the Greek Cypriot public although it was alluded to several times during the interviews. However my key informants very eloquently articulated their observations about the effects of migration on health and illness. Four of the six key community informants, were first generation Greek Cypriots whilst the other two, defined themselves as second generation (one had been born in Britain whilst the other had arrived here as an infant). As I argued in Chapters 3 and 4, the consideration of factors such as identity and migration is of immense importance when seeking to understand or explain the health and illness of the Greek Cypriot community. In focusing on the health of men, one of the informants described how, in the early 1950s and 1960s, many married men emigrated to Britain without their families, to escape poverty in Cyprus. They would work for months or years to make enough money so they could finance their family's journey to Britain. Many lived in appalling conditions, working long hours in restaurants and clothing *'sweatshops'*, and earning very little. The same informant stated that ***"...they escaped the poverty in Cyprus, the new settlers entered a new cycle of poverty and deprivation which was more foreign to them. Because the family and social systems which they were used to back in Cyprus were absent, they created small tightknit communities in England and often allowed themselves to be exploited by their relatives or other members of the Greek Cypriot community".*** As a result, many did not mix or have any dealings with the host community. Economically, they functioned outside the system, their employers did not afford them any rights, such as national insurance contributions, pension schemes, annual leave, union membership and so on. Their inability to speak

English, meant that many were not aware of their rights as citizens, nor were they encouraged to participate in civil life, and in any case they lacked the confidence and linguistic ability. Most of them, rationalised their way of life as a temporary situation; they were living in Britain only for a short time, until they made enough money to secure their return and their economic independence back in Cyprus. In recreating their village life in Britain, the village coffee shop became the centre of social life for men. (This incidentally still remains an important meeting place for many first generation men). Their only outlet was the coffee shop were they could talk, smoke, play *'tavli'* (backgammon), gamble by playing cards, drink coffee and sometimes eat. Many continued this lifestyle even though they had families. The coffee shop was and still is the man's world, a place were a man could behave in a *'macho'* manner, show off to his peers, get support, network, find a job, but also have male stereotypes reinforced and even -according to another of my informants- sometimes smoke a cannabis joint.

One of the ways that my key informants explained their views and conclusions about the health, illness and lifestyles of the Greek Cypriot community, was through the notion of *'feeling inferior'*. This, according to them stems from their early experiences in this country, and the fact that many of the early settlers were uneducated, poor peasants. Their early experiences of hostility from the indigenous population (not only because they were immigrants, but also because of the struggle for independence from British rule which was taking place in Cyprus in the 1950s), left them feeling like unwanted guests in this country. They had, prior to coming to Britain, seen British people as superior, richer, more educated, more powerful. One of my informants stated that ***"...Greek Cypriots feel subordinate to the English people although often they hide it. They try to protect their self image by trying to impress others particularly the indigenous population"***. Another informant stated that ***"...something which affects health is an inferiority complex which many Greek Cypriots have... as they grow older this may affect them mentally, some even become drug addicts"***. According to my informants, feeling inferior, leads the Greek Cypriots into two modes of action; they are either too submissive, being thankful for what the health system gives them, not wishing to *'rock the boat'*, not

exercising their rights and so on, and, at the other end of the continuum, being aggressive. Men in particular, may shout and threaten health professionals, will make unreasonable demands even when they have a legitimate case; however, one of my informants explained this behaviour as ***"...the result of being ignored and mistreated for years through being submissive"***. However it was pointed out that the younger generation is becoming more assertive.

Religion is another important foundation of the Greek Cypriots' lifestyles. One of my informants suggested that the Greek Orthodox religion provides useful principles for a healthy life. ***"...for example the fasting which it imposes helps to clean our body from the toxins of rich food"***. Another respondent mentioned that many first generation Greek Cypriots helped to establish the Greek church and most importantly the Greek schools. My informants argued that these schools could play an important role in the promotion of health within the community, not only by addressing health issues in the classroom, but also through helping young people to come to terms with their identity and thus lessen the stress between the generation gap. Another link between religion and health is the practice of many Greek Cypriots, particularly of the first generation, of **'ayiasmos'**. This entails either taking a sick person to the priest or asking the priest to visit as sick person; the priest reads a number of prayers and either uses holy oil or holy water on the diseased part of the body to promote healing. This form of spiritual healing is widespread amongst all generations, particularly for serious, life threatening illnesses and some people will visit churches in Cyprus or Greece which are named after saints who, from time to time become known for their miracles. Receiving the last sacrament is also considered very important for a dying person in their preparation for their journey to the next world.

Theme 2: Culture and health

Theme elements: Looking after yourself
The use of *'yiatrosophia'*

In the opinion of my informants, Greek Cypriots generally neglect themselves, although they argued that the younger generation tend to take better care of

themselves. The origins of this self neglect is to be found in experiences and lifestyles adopted by the first generation migrants. According to one of my informants this mentality could be described as *"work, buy, pay and buy again, until we reach an age when all of a sudden we are 50 or 60 years old and we realise that we have not lived like other human beings do. We have become so materialistic. House extensions, double glazing, modern kitchens, expensive furniture, cars and so on , seem more important than taking care of our selves".* They have no time to think about their health until they lose it. It was also argued that many Greek Cypriots do not know how to look after themselves, many holding incorrect assumptions about what a healthy lifestyle is. For example, some believe that they do not need to exercise because they go to work; but many, although at the end of the day, feel very tired, they have sedentary jobs such as the machinist, or jobs which required them to stand for 8 to 10 hours, such ironing clothes. One of the informants argued that Greek Cypriots are greedy people. *"As we have become wealthier, we have become greedier; we eat too many barbecues and mezedes. This is similar to what is happening in Cyprus at the moment. There is a saying in Cyprus, that people eat as though they will die tomorrow and build houses etc as though they will live for ever".*

Two of my informants mentioned the use of **'yiatrosophia'** which is a derogatory term of the term **'practica'** which was used during the group and individual interviews. **'Yiatros'** or **'Iatros'** is the Greek term for **'a medical doctor'** whilst **'sophia'** means **'wisdom'**; however this word is used in a pejorative sense, as the key informants thought that many of the traditional remedies had no scientific validity and therefore their use is of no value. Despite this, one of my informants mentioned the use of **'masticholado'** which helped particularly small children and babies who had chest infection or abdominal pain. This is warm olive oil in which a gum resin is dissolved (this resin is aromatic and is also sold as chewing gum, and is considered good for digestion). This mixture is then rubbed onto the child's chest or abdomen and is reported to have a soothing effect.

Theme 3: Culture and ill health

Theme elements: Mental health
The use of drugs
Ill health within the family

Mental illness was another topic which was not raised during the group and individual interviews with the Greek Cypriot public. But according to my respondents, the community has both mental illness and learning difficulties (mental handicap) problems. Both these topics, according to my informants are considered taboo or stigma. One of the informants stated that ***" ...certain cultural attitudes prevent people from admitting to having certain conditions and from seeking help. None more so than mental illness and mental and physical handicap. Often families hide it from others, tolerating situations and trying to cope on their own as best as they can".*** He recalled that once a mentally disturbed young man tried to attack someone with a knife, in the centre which he (the informant) runs. The young man's mother pleaded with the informant to allow her son to attend the centre saying that he only became aggressive when he did not take his medication. She eventually admitted that he was sometimes violent towards her but said, ***"he is my son, I can't throw him out in the streets, I have to care for him"***. According to the informant it became evident that, although the man was under a doctor, she had suffered in silence for years, devotedly caring for her son, bearing an enormous guilt for his predicament. Another informant referred to a woman who had worked with him for five years before she admitted to having a mentally handicapped child. The informant said: ***"She had kept it quiet because she felt so ashamed".*** Another informant argued that mental health very much depends on the family. ***"If the child or young adult lives in a warm understanding environment, the chances of him/her developing mental illness is very small. Mental illness is the absence of love and care".*** He went on to suggest that many Greek Cypriot families have communication problems. Parents and children do not communicate because the parents work long hours and spend little time creating channels of communication with their children. ***"...so year by year the child becomes more isolated from the parents (mainly the***

father) until s/he reaches adolescence and then the problems begin....this sometimes leads to emotional disturbance and mental problems".

Another important current issue which was not raised during the group and individual interviews, is that of drug abuse. According to one of the key informants, the Greek Cypriot community has a small scale drug problem. This was blamed on the feeling of inferiority which was discussed above and on the breaking down of family structures. Some of the first generation people who take mainly cannabis, started the habit to cope with stresses of life as migrants and because often they felt inadequate, inferior and depressed. Those young people of the second generation who become involved with drugs do so through their friends with whom they spend more time, as they see little of their parents, for reasons which were elaborated above.

The link between the function or dysfunction of the family and the health of family members has been referred to several times in this section. However, my key informants highlighted another problematic area which was briefly discussed during the interviews with members of the Greek Cypriot community. This is the male domination and the subsequent physical or psychological abuse which occasionally takes place. This is more prominent among first generation couples, but my informants suggested that this pattern is often replicated in second generation couples. The Greek Cypriot culture still considers the woman as inferior to man. Her primary role is to prepare for marriage and motherhood. She is responsible for maintaining the home and looking after the children. Although many first generation women worked long hours from home, their husbands still expected them to carry out all the domestic and child care responsibilities. Their financial contribution is taken for granted by their husbands who sometimes gambled their own money and that of the wife. Three of my informants suggested that it is not uncommon amongst the first generation men to batter their wives. One said, *"...where the Greek women differ from the English women is that they never admit to bad treatment from their husbands to the doctor because they feel very embarrassed, and they would never go to the police to complain".* Another said that middle aged women would

see him, to ask for help saying that now that the children have grown up they were planning to divorce their husbands and they were looking for accommodation.

Theme 4: Culture and the need for health services

Theme elements: The need for health promotion
The needs of the elderly
Mental illness
Training for health professionals
Need for more Greek Cypriot health professionals

All the key informants agreed that the Greek Cypriot community does not have, as one put it ***"an illness problem, but a health problem"***. By this, the informants explained that Greek Cypriots will not hesitate to go to the doctor when they are ill, although they do not always comply with the treatment, but that they need to be convinced of the value of prevention and positive health action. The informants identified the need for change in attitude and lifestyle, through the provision of relevant information and health education; the focus for this strategy must be diet, stress relief, exercise and smoking. Such a strategy must appeal to the Greek Cypriot psyche and idiosyncrasies and needs to be intense and continuous. The responsibility for this lies not only with the health services, but also, as my informants suggested, with the Greek community. All the Greek organisations should include health topics and information in their programme of activities. One of my informants suggested that a joint strategy could be developed between the health, the social services and the Greek community organisations.

Another concern of the informants was the growing needs of the elderly, many of whom speak no or very little English. One of them stated that ***"...our elderly will need centres which are predominantly run by Greek Cypriot workers for the next 20 years"***. This was justified on the basis of language but also of cultural and religious customs.

Mental illness was discussed above. The key informants articulated the need for a debate within the Greek community about mental illness and mental handicap. This would be the most productive action that needs to be taken in order to face existing prejudices and fears about these issues. Unless the community itself begins to deal with stigmas or taboos, it would be difficult for anyone else to provide for what the community truly needs.

The key informants agreed that ***"...public officers must understand the customs, traditions, religion, culture of the people they serve in order to communicate easier and understand their problems and needs and avoid misunderstandings".*** One of the informants argued that this was particularly important for the GPs who need to understand the whole person whereas for the hospital specialist this was not so important because ***"...for him you are an elbow, a heart, a kidney"***, and that ***"...the hospital specialist gets a report from the GP...he has no time to go into your whole history, he focuses on your disease"***.

Although all the key informants praised the NHS, all thought that there is a need for more Greek Cypriots to enter the health professions as they thought that they would understand the Greek Cypriot people better because ***"...they have similar experiences, or similar upbringing or hold similar values. This ability to understand and empathise, this special bond, has often helped them to succeed where non- Cypriot carers have failed".*** With regards to nursing and midwifery, they all echoed the views previously expressed in the group and individual interviews.

INTERVIEWS WITH GREEK CYPRIOTS WORKING IN THE HEALTH FIELD

Seven people were interviewed (n=7); of them three (n=3) were men and four (n=4) were women. They all spoke very fluent Greek. Two of them (both male) were General Practitioners: GP (a) was in his mid-thirties, second generation, the other, GP (b) in his late fifties, first generation. Two of them (both female) were working as link workers in a busy acute hospital trust; both were first generation although one of them had come to Britain as a child. The other three, included an osteopath, an

alcohol adviser, and one thalassaemia counsellor. These informants confirmed the majority of the previous findings. Any new information and any diverse information is reported in this section under the following themes which were extracted from the interviews:

Theme 1: Medical conditions

Theme elements: Most common conditions
Most problematic conditions
The decline of thalassaemia

Theme 2: Health problems

Theme elements: Occupational links
Alcohol abuse

Theme 3: Effects of culture on health

Theme elements: Suffering in silence
Making *'unreasonable'* demands
Somatising stress
Looking after their health

Theme 4: The provision of health services

Theme elements: Culturally sensitive care
Difference versus similarity

Findings and discussion

Theme 1: Medical conditions

Theme elements: Most common conditions
Most problematic conditions
The decline of thalassaemia

The most common medical conditions seen by hospital doctors either as in- or out-patients, were: Diabetes, cancers (especially breast, cervix, uterus, bladder), gall

stones, gynaecological problems, miscarriages/terminations of pregnancy, heart disease, haematological problems, skin conditions, strokes, fractures in the elderly, cataracts and psychiatric problems. GP (a) stated that the Greek Cypriots consume a diet high in fat and ***"...one gets the feeling that the rate of heart disease is quite high within our community but there are no figures that I am aware of, so I cannot say if it is higher than the rest of the population".***

The most problematic conditions according to the two hospital link workers were: Diabetes, cancers, gynaecological conditions and gall stones.

All informants agreed that thalassaemia major has almost been eradicated from the Greek community as a result of screening and genetic counselling. However, the levels of carriers remains high and therefore the community and the health services must continue with a vigilant programme.

Theme 2: Health problems

Theme elements: Occupational links
Alcohol abuse

The informant who practised osteopathy outside the NHS, reported that most of his Greek Cypriot patients were suffering from conditions which clearly related to their occupations. The majority of his clients were men who worked as restaurateurs, waiters or builders or women who are machinists. Back ache and other back problems are the result of them having a bad posture for years and of either sitting or standing for too many hours.

The alcohol adviser discussed the results of a study she conducted in the Cypriot community (Greek and Turkish). The study showed that the level of harmful consumption in the Cypriot community appears to be considerably higher than that of the overall population. Regular and harmful drinking was reported by the younger group. There were twice as many male drinkers as female ones. There was lack of knowledge as to what constituted *'safe limits'* , combined with lack of concern

around health and health risks which seemed to create a belief of immunity and unproblematic use in the community. Denial of the problem, especially by male problem-drinkers was reported by many women. Issues around domestic violence and stigmatising attitudes, both relating to *'alcoholism'* as well as *'the inability to cope with and keep a problem within the family'* were also prominent. GP (a) stated that alcohol was socially very acceptable and many men seem to drink excessively.

Theme 3: Effects of culture on health

Theme elements:
- Suffering in silence
- Making *'unreasonable'* demands
- Somatising stress
- Looking after their health
- Cultural identity and health

The informants reported that most of the Greek Cypriots do not complain or make a fuss about their health problems. ***"The majority (especially the women) suffer in silence"*** said one informant. They do not wish to rock the boat as they think they may not get the best treatment if they make a fuss.

However a minority are very demanding. According to one informant ***"...they make up for the rest...they are the cause for the unfair labelling of the rest of the Greek Cypriot patients; they expect everything and want to have every test they hear about".***

GP (a) argued that Greek Cypriots tend to somatise increased levels of stress and anxiety into physical symptoms at much higher levels than the indigenous population. He said that ***"...many of the first generation Greek Cypriots tend to consult inappropriately; they frequently come to see me for what I would call trivial things, often as I mentioned, due to somatisation of their anxieties, yet, when they have a real fear that they may have a disease they will delay coming to the doctor. Men do not see me frequently; it could be because they dump all their anxieties***

on the women. The younger generation, generally seem to consult more appropriately".

Some of the informants argued that many Greek Cypriots are ignorant about health promotion and do not know of, nor do they appreciate the importance of preventative tests such as smears and breast tests. Some women had told them that they needed to seek the permission of their husbands before they underwent these tests as well as receiving treatment for family planning. One informant reported that many Greek Cypriots only become aware of the health services available after they become ill. Once they become aware of the services, often they will have high expectations. The informants echoed previous findings about the materialistic attitudes of many Greek Cypriots. This, leads many to self neglect, as in the opinion of my informants, they do not take exercise and they are overweight. GP (a) argued that the problems of wrong diet are compounded by the lack of physical activity. *"Leisure in our community does not include activities such as swimming, walking, jogging, or taking part in sports, although there are exceptions as in the case of young men playing football. Leisure for most means meeting friends or family usually to eat, drink, smoke and talk".* GP (a) suggested that (Greek Cypriots), on one level they seem to lack knowledge on issues such as diet and exercise and on other level they do not seem to understand the changes which were happening in the NHS and therefore do not appreciate the consequences of these changes. GP (b) disagreed with this proposition and argued that Greek Cypriots look after themselves and most seem to be well informed about diseases and their treatments, citing as an example a woman who had read in a Greek magazine about hormone replacement therapy (HRT) and who asked him to prescribe it. He said that his Greek patients *"...when they come to see me they know what they want from me".*

GP (a) emphasised the health needs of 18 to 20 year olds which seem to be directly linked to cultural identity. He said *"...they present to the surgery with physical symptoms such as pain which when you delve into it, is the result of psychological stress and anxiety from parental relationships and often related to issues of sexual*

freedom". Older people on the other hand, somatised their psychological problems which had their roots in work, marital disharmony or their relationships with their children.

Theme 4: The provision of health services

Theme elements: Culturally sensitive care
Difference versus similarity

The two link workers reported that both nurses and doctors are sympathetic and tolerant with the Greek Cypriot patients although they reported that patients had complained to them about the uncaring attitude of some night nurses. GP (a) stated that health care professionals need to learn about the Greek Cypriot community during their training and to have information available for reference. But unfortunately, according to him, the body of knowledge does not yet exist. The thalassaemia counsellor, stated that the service is culturally sensitive and that thalassaemia is probably one of the few health problems which are understood and provided for.

In order to address the issue of whether or not the provision of services which target the needs of the Greek Cypriot community are needed, GP (a) suggested that the health problems of this community must be quantified through research. ***"We will then be able to compare this with that of the rest of the population and establish whether or not our community truly has specific needs".*** GP (a) stated that GPs try to assess and deal with the needs of their patients during consultation. He argued that this assessment is not to the level or standard they would like it to be. He also stated that ***"...I am afraid my views have no way of being fed into the Health Authority system. They have not asked me to contribute to any of their assessments as a Greek Cypriot GP".*** However GP (b) stated that the Greek Cypriot community, with the exception of some first generation persons who did not speak English, had no special or different needs. According to him health was the lack of disease and did not think that the cultural or ethnic background of a person influences his/her health needs. ***"My Greek patients have the same problems as the rest of my patients, they***

are no different". In his view there are two kind of patients independent of their cultural backgrounds: ***"those that would avoid visiting the doctor, and those who would see him morning, afternoon and evening, if they could".*** Both GPs were very critical of the NHS. GP (b) said that ***"...if the services were improved and were good, they would be good for everybody".*** All informants, including GP (b), referred to the problems which people who do not speak English must have before and after they access any health service. They all linked this, to the needs of the elderly.

SUMMARY

This chapter presented and discussed the findings of an in-depth exploration of the health beliefs, lifestyle behaviours and perceived health needs of the Greek Cypriots from three different perspectives. The chapter highlighted the relationship between culture and health as viewed by the participants.

The next chapter presents and discusses the findings of a health a lifestyle survey of 151 randomly selected Greek Cypriots living in two North London Boroughs.

CHAPTER 8

THE HEALTH AND LIFESTYLE SURVEY

INTRODUCTION

There has never been a comprehensive survey of the health status or lifestyle of the Greek and Greek Cypriot people living in the United Kingdom. This is not surprising, since the recognition by the government and by health professionals of the need to study seriously the health variations of ethnic groups living in the UK, is relatively recent. Indeed, as discussed in Chapter 1, it was not until 1992, that the Chief Medical Officer's report *'On the State of Public Health 1991'*, emphasised that many of the government policies and service development initiatives could not be achieved unless the health of ethnic minorities was improved.

In general terms, even baseline demographic data about the Greek Cypriot community has been lacking; the most authoritative source of demographic information in Britain, the decennial census, did not, up until 1971 include any questions relevant to ethnicity. The 1971 census asked for country of birth and that of the parents. By 1991, the census included a list of eight ethnic groups plus a category for *'any other'*. In the 1991 census, people of Greek and Cypriot origins were classified as *'white'*, since these communities were not thought by the OPCS to be sufficiently large to warrant separate identification, although the census required individuals to specify their country of birth.

Doctors, nurses and other health professionals as well as medical sociologists have failed to investigate the health and health care needs of Greek Cypriots living in the UK. Possibly one exception, has been that of thalassaemia, an inherited type of anaemia which does not only affect the Greek Cypriots but also many individuals who originate from Mediterranean and Asian countries.

THE SURVEY

The information included in this chapter, is derived from a survey of 490 randomly selected Greek and Greek Cypriots living in the London Boroughs of Enfield and Haringey, which I conducted during 1995. The two neighbouring boroughs are co-terminus with the New River Health Authority, now known as the Enfield and Haringey Health Authority. They have the highest concentration of Greek Cypriot people in the United Kingdom. The 1993 publication of the *'New River Sector Profiles'* states that the largest minority ethnic group in New River are the Cypriots (Greek and Turkish) who form 6.9% of the total population in the two boroughs. The 1991 OPCS Census showed that in Haringey, 11,593 residents reported that their head of household was born in Cyprus. This represents 5.7% of the total population of Haringey (202,204 residents on census night). In Enfield, the persons in households headed by a Cypriot is 7.9%, some 20,400 residents out of the 257,411 total population of the borough (Enfield Planning Information, November 1993). These figures represent both Greek and Turkish Cypriots and are generally considered to give only a part of the total figure. Indeed, in January 1994, the Environmental Services of London Borough of Enfield, having adjusted the available census figures, estimated that the Cypriots in Enfield amounted to 25,000, or 9.5% of the total population. In the absence of any demographic evidence which gives a breakdown of the ratios of Greek and Turkish Cypriots, the London Borough of Enfield have used as a guide, the findings from a School Language Survey which was carried out in the borough in 1990. This found that 63% of school pupils were Greek speaking and 37% Turkish.

I had intended to use in my analysis, references to health data which might have been available by the Cypriot government. I considered that this might well have supplemented the dearth of data from the UK and might contribute to an understanding of the health status of the Greek Cypriots in the UK. This position is based on the view that the Greek Cypriot community in the UK maintains a strong sense of ethnic identity which influences their lifestyles in similar ways as those who live in Cyprus (Constantinides 1977, Anthias 1992). However, the information available was mainly based on diseases, hospitalisations, and attendances at out-patients departments,

supplemented with information about the available medical and para-medical services (Dept. of Statistics and Research, Ministry of Finance, 1993). It was thus of limited use to my study. In addition up until 1995, the Cypriot government had not undertaken a national health and lifestyle survey.

As one of my study's question was to explore how the health beliefs, lifestyle behaviours and health status of the Greek Cypriots differed from those of the majority white population of England, I decided to compare my findings, where possible, with those from the *'Newcastle Health and Lifestyle Survey 1991'* (to be referred to as NHLS 91) (Harrington et al 1993) and where appropriate with the findings of the *'Health Survey for England 1991'* (to be referred to as HSE 91) (White et al 1993). Naturally, neither of these studies were designed exclusively for the majority white population. The NHLS 91 was based on the findings of 4139 completed questionnaires from men and women aged 16 to 74 years. The HSE 91 involved 3,242 adults aged 16 years and over. Whilst the NHLS 91 did not include an ethnicity field, it was chosen because my questionnaire was based on it with only a few minor modifications. The HSE 91 reported that 95% of the sample were *'White'*. Therefore, it would be more accurate to state that my findings are compared where possible to two *'Health and Lifestyle Surveys'* which were based on representative samples of the whole population in a) Newcastle and b) England. A brief summary of the two comparison surveys - as well as of the *'Health Survey for England 1994'* (Colhoun and Prescott-Clarke 1996) which was published after this chapter was completed- are appended.

THE SAMPLE

The sampling frame for my survey was drawn from the electoral rolls of the two boroughs. As discussed in Chapter 2, a computer programme which was able to recognise Greek names was used to create a list of 2,735 names of Greek/Greek Cypriot voters in Haringey and 8,433 names of Greek/Greek Cypriot voters living in Enfield.

A postal questionnaire based on the Newcastle Health and Lifestyle Survey (NHLS 91) was sent to the sample as shown below (Table 8.1). As can be seen from the table the number of females in the sample was greater than males (56.7% and 43.3% respectively). Some of the questions were modified or specifically designed for this survey and were tested in the pilot study which included 30 individuals.

Table **8.1: The sample of the main study**

BOROUGH	MALES	FEMALES	TOTAL
Enfield	110	139	249
Haringey	102	139	241
TOTAL	212	278	490

Of the 490 subjects, 151 returned their completed questionnaires. Twenty seven (27) were returned by the post office presumably because the person to whom the questionnaire was sent, no longer lived at the address. Another eight (8) were returned with a note stating that the questionnaire was too personal or too long. As discussed in Chapter 2, for various reasons and due to lack of funds as the study was self-funded, reminder letters were not sent to those who failed to returned their questionnaires. Taking into account the returned but uncompleted questionnaires, the response rate was 33.2%. Although it was hoped that the response rate would be higher (50%), considering the length of the questionnaire and the lack of follow up, this was not totally unexpected. Hedges (1978) states that non-response can be a source of bias since non-respondents may well differ in characteristics from respondents. However, it was not possible to follow up non-respondents, because, as explained in the methodology chapter, the questionnaires were sent out unmarked, in an attempt to reassure the recipients of the complete anonymity of the data thus encouraging more of them to return them. Therefore, the findings have to be viewed with caution. However, there is a lack of consensus in the literature regarding what constitutes an acceptable response rate. The difficulties associated with researching *'hard to reach'* groups are acknowledged and various tactics to improve response rates are recommended (Bruce

et al 1994). Although, through doubling the required sample size from 245 to 490 I had compensated for the numerical loss which enabled me to undertake descriptive and in some cases inferential statistical analysis, the problem of bias remains. The various sections which follow, make references to the limitations of the findings.

THE QUESTIONNAIRE

The questionnaire consisted of a total of 88 questions (361 variables) which covered the following 12 areas:

1. About yourself
2. About your health
3. Food
4. Alcohol
5. Activity at work and leisure
6. Smoking
7. Stress in your life
8. About your home, family and social life
9. About your health and your doctor
10. Your views about health and illness
11. Finding out about health issues
12. Your views

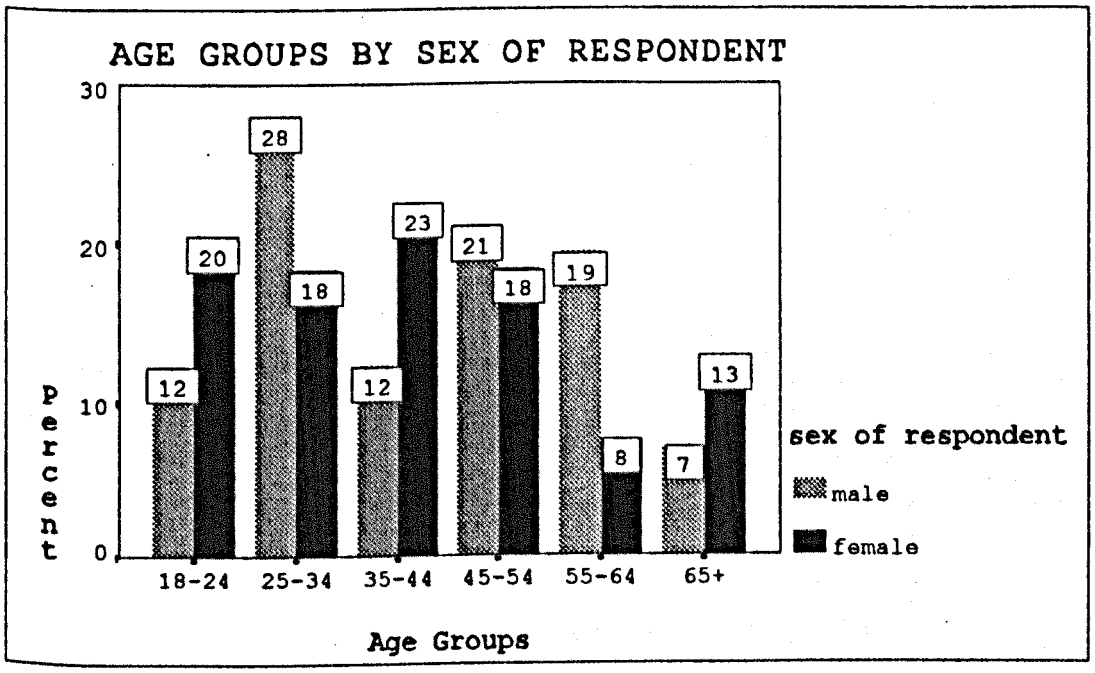
Each questionnaire (which was in English only) was accompanied by a letter in English and a letter in Greek, giving information about the study, emphasising the confidential nature of the information given and also asking those who needed help with the completion of the questionnaire to contact me.

CHARACTERISTICS OF RESPONDENTS

Age and sex distribution

Almost two-thirds of the respondents were female (62%). This indicates an over-representation of women and a response bias associated with gender. However, this was not entirely unexpected due to the higher ratio of females to males in the sample (1.3:1.0). It is also interesting to note that the NHLS 91 study also reported that males were overall under-represented (35% versus 65%). The HSE 91 reported that of those who were interviewed 46% were men and 54% were women. In my study (to be also referred to as GCS 95), the age of respondents ranged from eighteen to eighty-two with a mean age of forty two years. As figure 8.1 illustrates, the proportions in each age group varied between the sexes. A smaller proportion of men in the 18 to 24 age group responded than women in the same group. This was reversed in the 25 to 34 age group and in the 55 to 64 age group.

Fig 8.1: **Gender age groups**

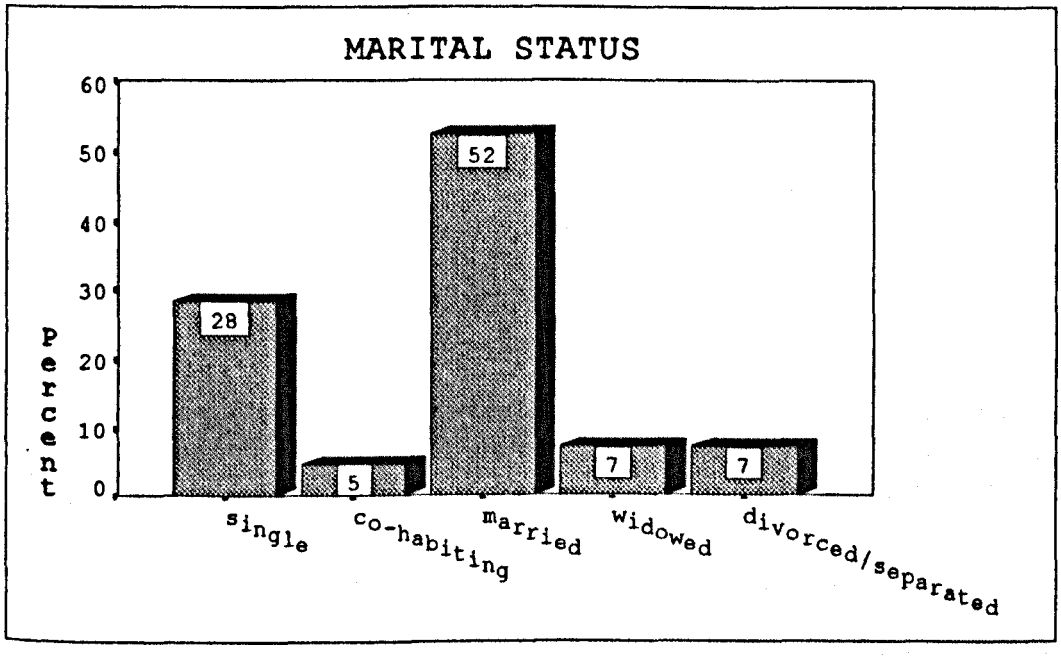


Marital status

Just over half (52%) of the respondents reported they were married (figure 8.2) and just over 5% said they were co-habiting. Just over 28% reported to be single. Equal

proportions (7%) reported they were widowed or divorced. The NLHS 91 reported similar findings. Married (56%), co-habiting (6%), single (24%), widowed (7%), and divorced (8%). The HSE 91 reported that from those who were interviewed, 59% were married, 6% were cohabiting, 19% were single, 9% were widowed and 7% were divorced or separated.

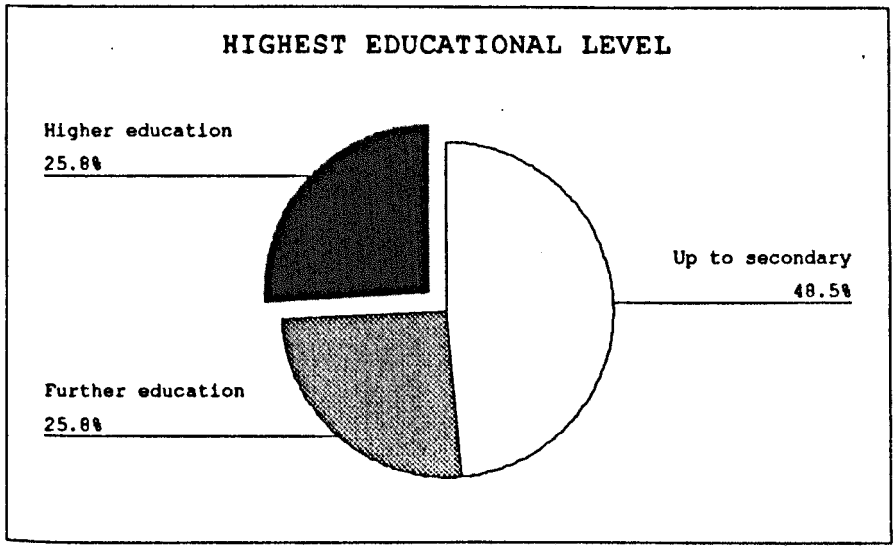
Fig 8.2: **Marital Status**



Education

The pie chart in figure 8.3 illustrates that about half (51%) of the respondents had received some post-secondary education. A quarter reported that they had attended an arts and technology college or other form of college. The same proportion attended a higher education institution such as Polytechnic or University. The NLHS 91 study reported that only 30% of the respondents attended post-secondary education, whilst the HSE 91 reported that on average 31% of the respondents had "A" levels or above.

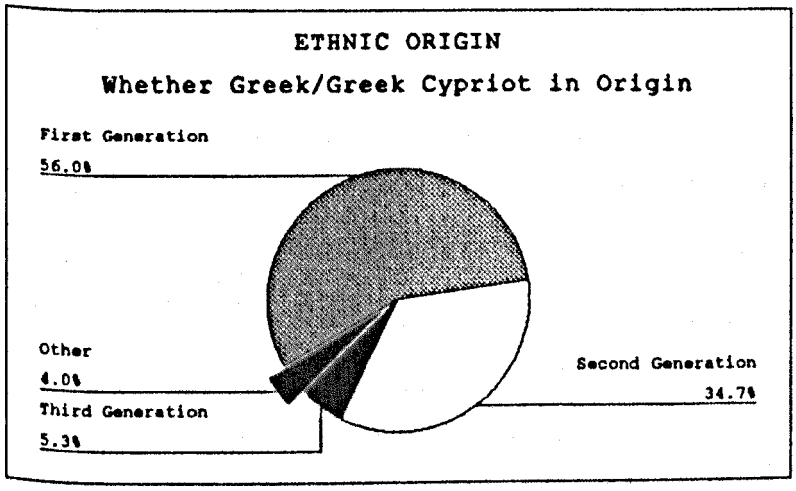
Fig 8.3: **Highest educational levels**



Country of birth and generation

Respondents were asked to indicate which generation Greek or Greek Cypriot they felt best described themselves (figure 8.4). A small majority (56%) reported that they were first generation Greek/Greek Cypriot. Just over one third (35%) were second generation and the remainder (5%, n=8) were third generation. Six respondents (4%) had one Greek or Greek Cypriot parent. When asked their country of birth, 56% said they were born in Cyprus, less than 1% were born in Greece and 44% were born in Britain or elsewhere. In view of the very small percentage of individuals born in Greece, the sample will be referred to as Greek Cypriots.

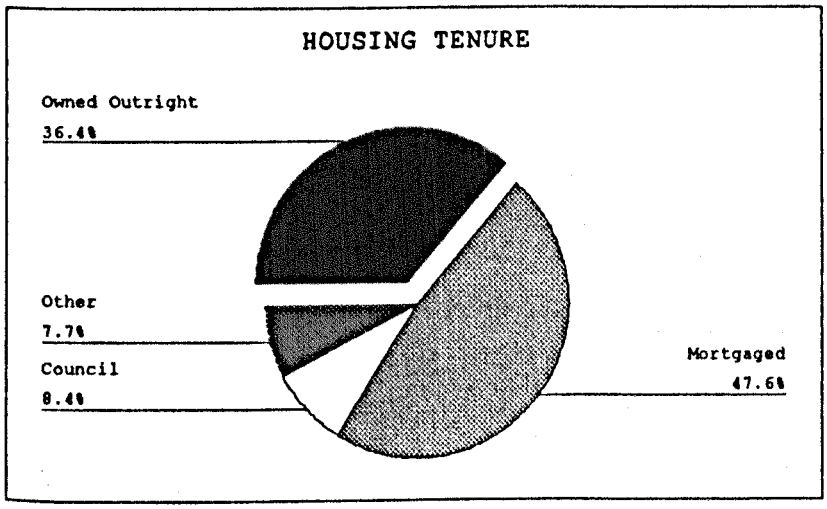
Fig 8.4: **Ethnic origin**



Home and family

The largest proportion of respondents said they were living in a property they were buying (48%), or that they owned outright (36%). Only 16% lived in property rented by the council, housing associations or private landlords (figure 8.5). The vast majority (99%) had their own bath or shower and 98% had partial or full central heating. Respondents were asked to record the number of rooms they had use of, excluding kitchens and bathrooms. 39% reported that they had six or more rooms in their home, and 7% had only two rooms. The NHLS 91 reported that 41% of the respondents were buying their homes, 19% owned them outright, 39% were living in rented accommodation. The HSE 91 reported that 64% either owned outright or were buying their homes and 36% were living in rented accommodation.

Fig 8.5: **Housing tenure**



Respondents were asked to state the number of children up to age sixteen they had living in their home (Table 8.2). Of those who responded, almost 61% said they had no children living in the household. Family size was generally small with most households having only one or two children living with them (18% and 14% respectively). 8% reported to have larger families. The HSE 91 reported that 19% of households had one or two adults and one or two children (under 16 years). 7% were identified as large families (3 or more children under 16 years).

Table 8.2: **Number of children up to age sixteen living in the household**

	%	(N)
No children	60.5	(75)
1 child	17.7	(22)
2 children	13.7	(17)
3 children	6.5	(8)
4 children	1.6	(2)
Missing value	17.6	(27)

Including those who had no children living with them, 11% of households had one child under five years of age and 2% had two. Larger proportions of households had children aged five to fifteen years: 20% had one, 14% had two and 3% had three.

Employment and income

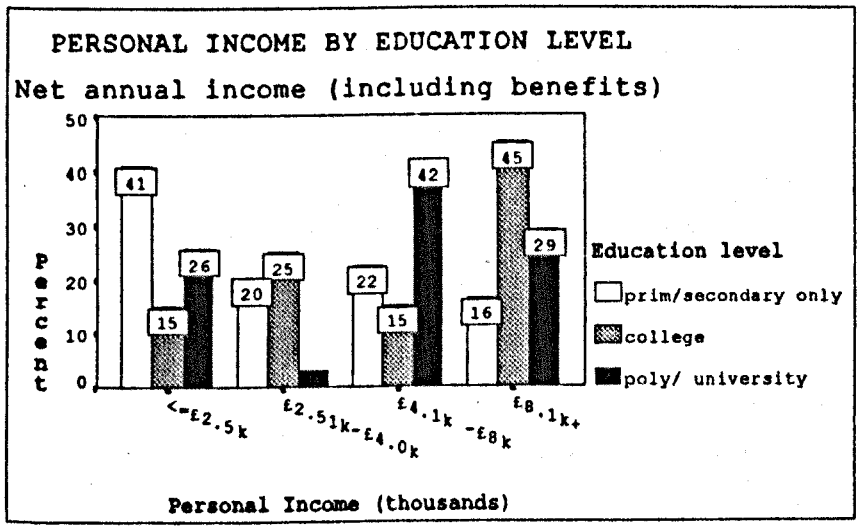
35.4% of the respondents reported to be in full employment, 6.1% to be in part-time employment, 1.4% to be self-employed or to be an employer, 2.6% as waiting to start a job they had already accepted, 1.4% to be on a government training scheme, 8.2% to be in full-time education, 4.8% to be unable to work because of long-term illness or disability, 24.7% reported that they were looking after the home or family, whilst 14.4% answered the question labelled as *'other'*, most reporting to be retired (20% of the total respondents were aged 65 years and over). 7.5% reported to be unemployed and looking for work. Table 8.3 provides a comparison with the other two studies referred to throughout this chapter. The category *'working'* includes those working full and part-time, the self-employed, those waiting to start a job and those on a government training scheme. The category *'economically active'* includes students, and those looking after family.

Table 8.3: **Economic activity**

EMPLOYMENT STATUS	GREEK CYPRIOTS	NHLS 91	HSE 91
Working	46.9%	56.5%	55%
Unemployed	7.5%	7%	5%
Economically active	32.9%	20%	40%

Respondents were asked to give their annual household income after tax, in one of 12 categories. Seventeen respondents (11%) did not answer this question. In line with the NHLS 91 study, the personal income was calculated by taking the midpoint of each income group and dividing it by the number of adults in the household. Forty two respondents (28%) had missing data either in relation to income or regarding the number of adults in the household. From the respondents who were included in the analysis, 23% had an income of up to £2,500 per annum, 17% between £2,500 - £4,000, 26% between £4,100 - £8,000 and 25% earned more than £8,000 per annum. There was no income difference between the sexes. However there was a marked association between income and education level as figure 8.6 illustrates. Those with only a secondary education were much more likely to have a low income: 41% had an income of up to £2,500 compared with 15% of those with a college education and 26% of those with a University or Polytechnic education. At the top end of the income scale, those with a college education (further education) more frequently earned more than £8,000 than did those who had been in higher education (45% versus 29%). Only 16% of those without further education earned over £8,000 per annum.

Fig 8.6: **Personal income by education level**

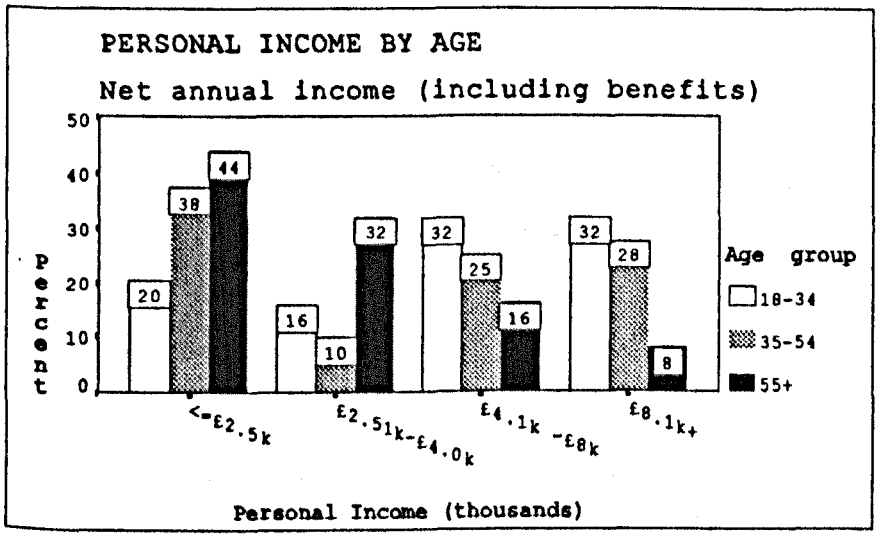


Also correlated with personal income, was age. Figure 8.7 shows that those in the 18-34 year age group were relatively better off especially when compared with those in the 55

years plus group. The latter were three times less well represented in the £8,000 a year income group than those aged 18-34; this may in part be accounted for by the large proportion of pensioners in the older group.

The NHLS 91 reported that the average income in the sample was £10,000 although 54% of the respondents earned less than £10,000 with 28% of them earning less than £5,000. Overall women had lower incomes than men. Income was also influenced by age, with the young and old having the lowest incomes.

Fig 8.7: **Personal income by age**



Discussion of findings

The report by the London Research Centre (1994), entitled *'London's Ethnic Minorities: One City Many Communities. An analysis of the 1991 Census results'*, states that there were 50,684 people living in London but born in Cyprus. As discussed earlier in this chapter, over 31,000 of them live in Enfield and Haringey. Naturally, Cypriots are both Greek and Turkish and the OPCS statistics do not differentiate, but, considering the demography of Cyprus and the patterns of migration, Anthias (1988) estimates that approximately a quarter are Turkish and the remainder Greek. These figures are grossly underestimated as they exclude households headed by Cypriots born in the UK. It is therefore fair to say, that the needs of this large community group must be identified and understood both by the health care providers and by those who commission and

purchase health services.

The findings indicate than more than half (56%) of the respondents are first generation Greek Cypriots. If we consider that 23% of the sample are 55 years or over, it means that 33% of the sample are first generation migrants below the age of 55; these figures clearly demonstrate the relevance of culture on health behaviours. Constantinides (1977) wrote that the interesting point about the Greek Cypriots, is their potential invisibility within the British majority population. Yet, in spite of this, those who have written about the Greek Cypriots in Britain (George and Millerson 1967, Oakley 1970 and 1987, Constantinides 1977, Anthias 1992), have commented upon their strong sense of ethnic identity.

Marriage is an important institution within the Greek Cypriot community. Constantinides (1977) found that even second generation Greek Cypriots wished and expected to marry within the community. Once married, it is exceedingly difficult to get a divorce as the Greek Orthodox Church recognises very few grounds for divorce, although recent anecdotal evidence both from Cyprus and the London Greek Cypriot community seem to indicate an increase in divorce rates, which may reflect an adjustment to social realities on behalf of the church. The evidence from this study, seem to support this position, as they show divorce/ separation rates to be similar to those found in the general population. Co-habiting is generally disapproved of by parents and friends and when it happens, those concerned do not freely admit to it. Paschalis (1986) reported, in a study about the position of women conducted in Cyprus in 1978, that 76% of the respondents were definitely against co-habiting, and 83% of the respondents believed that only in marriage should sexual relations be consummated, thus considering marriage as the only framework of a permanent bond. However the findings of my study are showing that the number of people who are co-habiting to be very similar to those found in Newcastle, but much lower than the national figures reported by the HSE 91 survey.

The results of my study reveal that Greek Cypriot families are small and similar in size

to those of the indigenous population, with the majority of families having 0-2 children. Bearing in mind that there is an over-representation of women in the sample of my study, it is not surprising to find that almost 25% of the respondents described their work status as *'looking after the home and the family'*. This finding indicates that these activities remain the woman's domain. It is however likely that many of these women are working very hard sewing clothes from home, for low wages, outside the employment regulations. This means that they are not legally employed and therefore have no employment rights. Anthias (1992) reported that Greek Cypriot men still expect their wives to be solely responsible for child care and domestic labour even when they work full time. For many women this inequality within the marriage causes enormous stress which sometimes leads to marital difficulties and even physical and mental illness (Papadopoulos and Worrall 1996).

Education is also highly valued amongst the Greek Cypriot community. The findings of this study confirm Anthias' (1992) assertion, that educational achievement is a dominant value for the Greek Cypriots and may be regarded as an important element of class and ethnic adaptation. She reminds us that the Cyprus Educational statistics show that more than 50% of those who complete their secondary education go on to higher education. The are clear parallels between the trends in Cyprus and the UK. As already mentioned above, Greek Cypriots retain a strong sense of ethnic identity. This is both manifested and maintained through regular holidays in Cyprus, through a continued interest about the social, political and economic situation in Cyprus and regular update of these through Greek newspapers, Greek radio and more recently through the reception of Greek television (from Cyprus and Greece) via satellite or cable which many Greek homes have. My findings show that a high proportion of the Greek Cypriot population (just over 51% of the respondents) have received post- secondary school education, something which needs to be noted by health providers and purchasers when planning health promotion campaigns or when dealing with them as clients in general.

Home ownership in Cyprus is extremely high, and families expect to help substantially towards the purchase of one, as a wedding gift to, mainly, their daughters. Owning your

home is considered the foundation of the nuclear family (Constantinides 1977, Anthias 1992). This belief is very much evident within the Greek Cypriot community in the UK. It is not surprising therefore that 84% of the respondents either own outright or are buying their homes. Home ownership in the New River Health Authority catchment area by the general public, is reported to be in the region of 60%. However, as discussed in Chapter 3, levels of ownership do not tell us the general condition of the dwellings. Nevertheless, my study also reported two other relevant findings: that most Greek Cypriots of Enfield, live in the more affluent parts of the borough, and that the level of unemployment amongst the Greek Cypriots is lower than the *'white'* category (in which they are included) reported for Enfield and Haringey (10%) and much lower than some of the other ethnic groups living in these two boroughs, for example 22% for the Bangladeshi community. But if the findings about employment and income, which indicate that the majority of the respondents have low household incomes, are to be considered, it becomes obvious that to achieve home ownership, many families make enormous sacrifices. It is assumed that a large proportion of their income goes towards mortgage payments, which may have negative consequences on other activities such as leisure, and on the levels of stress experienced by the respondents.

RESPONDENTS' HEALTH STATUS

Physical characteristics

Respondents were asked to record their height and weight. Body Mass Index (BMI) gives a measure of the relationship between weight and height [BMI = weight (kg) / height^2 (m)]. BMI figures were calculated for all those who reported their height and weight. The raw BMI figures were then grouped into categories representing *'underweight'*, *'healthy'* *'overweight'* and 'obese'. The criteria used as threshold parameters are those adopted by the Royal College of Physicians (OPCS 1991). The parameters for each category vary by sex due to differences in relative amounts of muscle and body fat between the sexes. Figure 8.8 illustrates the proportion of men and women in each BMI category. This shows that very few men or women in the sample were underweight but it was slightly more common in men (6% versus 5%). The largest

proportion of both men and women fell into the *'healthy'* category (59% of men and 45% of women). Women had a greater tendency to be obese (18% versus 6%). BMI also varied with age and as the boxplot in figure 8.9 shows, as age increases so too does BMI for women although this is not the case for men.

The NHLS 91 study reported that overall, men were more likely to be above an acceptable weight for their height than women. However, a significantly higher population of women fell into the obese category than men (18% versus 8%). The study also found a positive correlation between age and BMI. In the 1991 Health Survey for England, it was found that more than half (53%) of men and 44% of women were considered to be overweight or obese.

Fig 8.8: **Body Mass Index by gender**

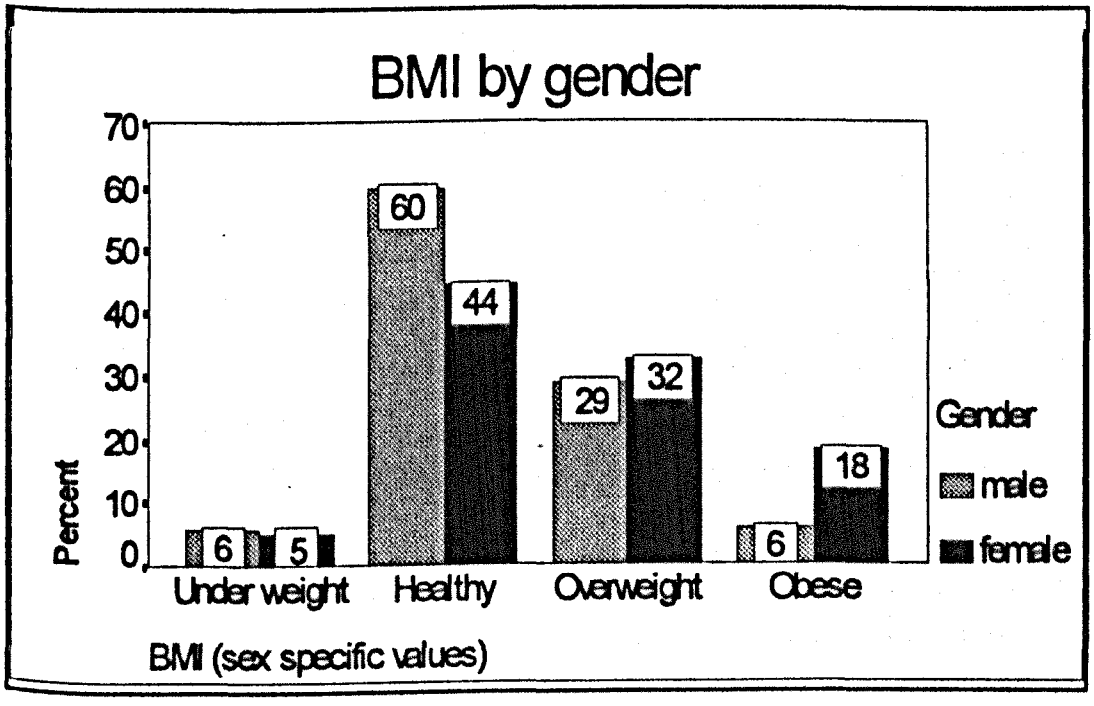
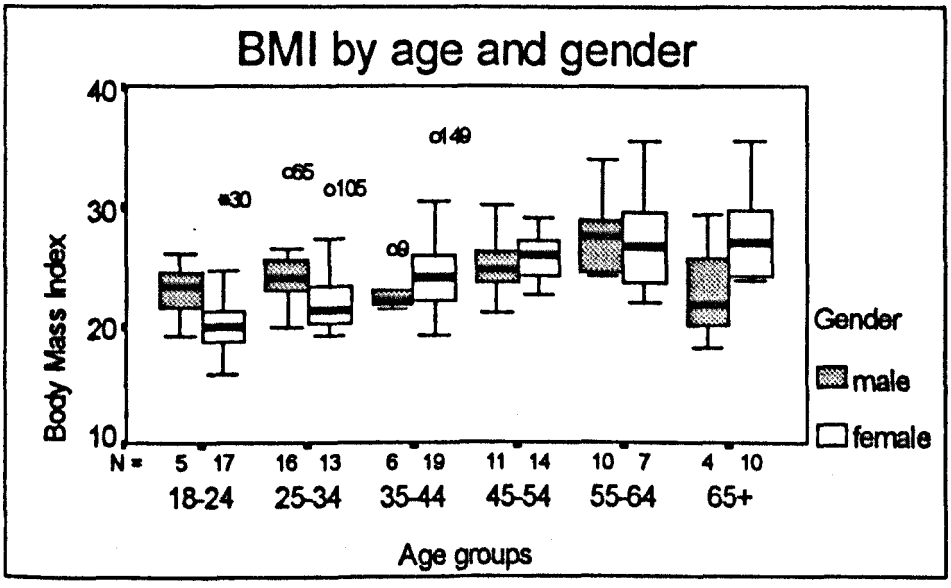


Fig 8.9: **Body Mass Index by age and gender**

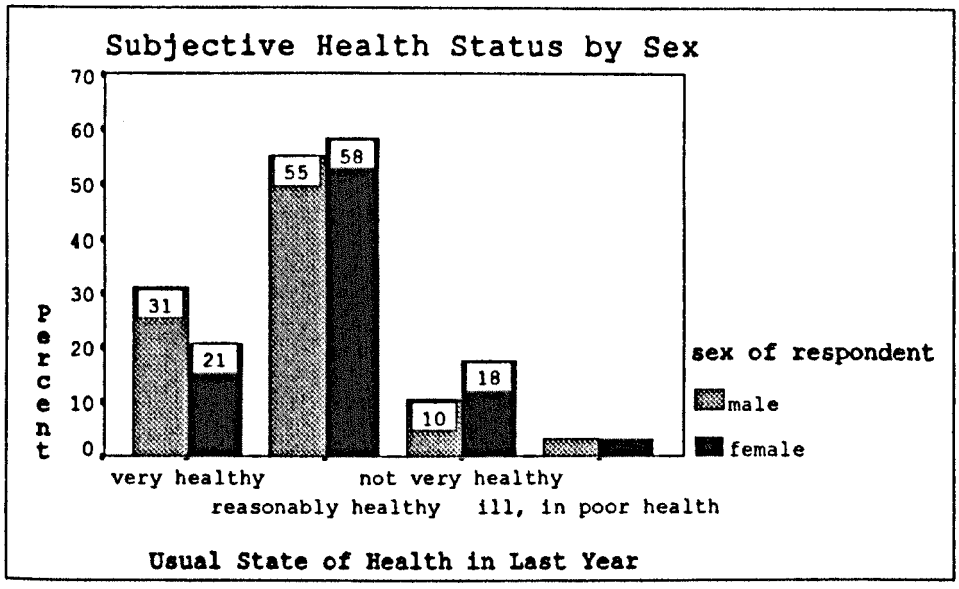


Perceived health and fitness status

Respondents were asked a series of questions about their and their family's health. When asked to rate their usual state of health over the past twelve months, a quarter (25%) rated themselves as having been *'very healthy'*, over half (57%) as *'reasonably healthy'*, 15% as *'not very healthy'*, and 3% as *'definitely ill or in poor health'* (figure 8.10). There were however, differences between age groups. Nobody in the 18-34 age group described themselves as *'ill or in poor health'* and they more often described themselves as *'very healthy'* than the middle or older age groups (49% versus 11% and 6% respectively). The middle age group was more likely to describe their health as *'reasonable'* than the others. Subjective ratings on health status were found to have a small association with sex but it was not statistically significant.

The NHLS 91 found that men and women were equally likely to perceive themselves as *'healthy'*, but more men than women considered themselves *'not very healthy'* or *'in poor health'*. The HSE 91 found that 78% of men and 75% of women thought that their health was very good or good. These proportions fell with increasing age.

Fig 8.10: **Perceived health status by sex**



Respondents were asked to rate their present physical fitness for their age using a five point scale. Fifteen subjects (10.1%) rated their fitness as *'very good'*, thirty seven (24.8%) as *'good'*, seventy three (49%) as *'reasonable'*, twenty (13.4%) as *'poor'* and four (2.7%) as *'very poor'*. Therefore 83.9% of the respondents considered themselves to be reasonably healthy for their age, which is consistent with their perception of their sate of health reported above. Figure 8.11 indicates the fitness levels as they relate to age whilst figure 8.12 relates to fitness and gender.

Fig 8.11: **Perceived fitness level by age**

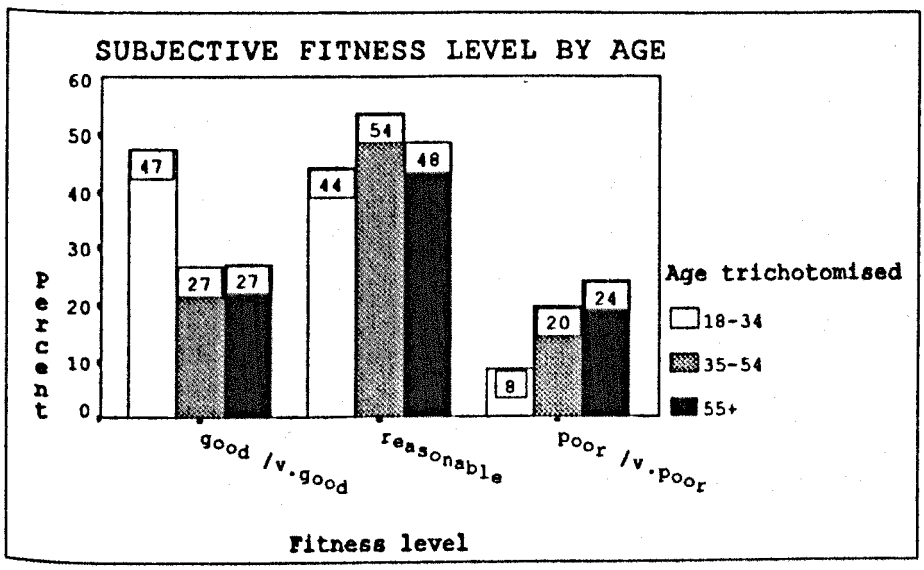
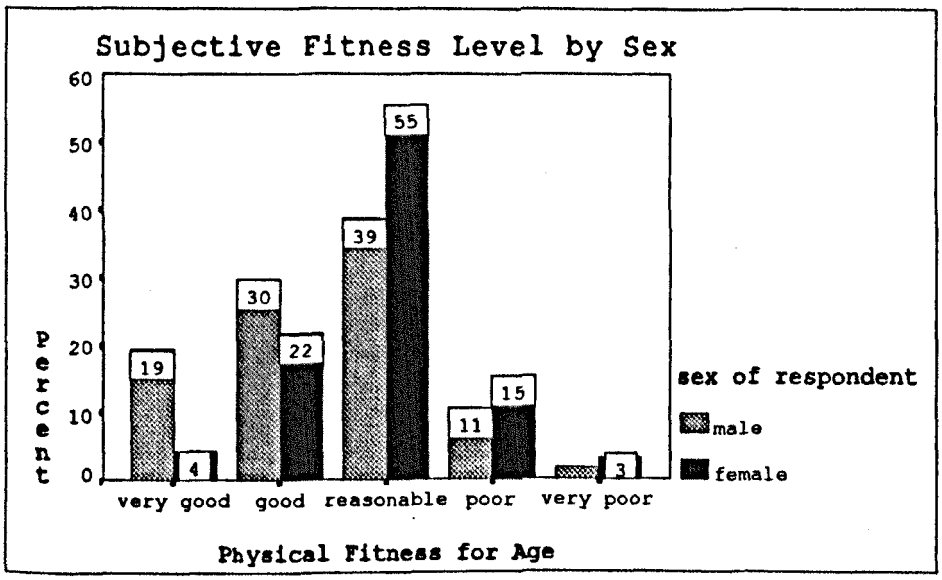


Fig 8.12: **Gender differences in perceived fitness level by sex**



Healthy behaviours

Participants were asked to report whether they did anything to keep themselves healthy. 51% (n=74) reported that they did do something and 49% (n=71) that they did nothing. They were then asked to list the three most important things which they did to keep healthy. The three most popular healthy behaviours were: take exercise, eat healthy food and stay happy by occupying oneself mentally and physically. Other responses included reduction in smoking and alcohol, taking vitamin pills and taking treatments prescribed by the doctor.

Unhealthy behaviours

Participants were then asked to report if they did anything which involved risking their health and to list the three risky or unhealthy behaviours. 33.3% (n=49) reported that they did risk their health whereas 66.7% (n=98) reported that they did not. By far, the most risky behaviour which was reported was smoking, followed by long working hours or dangers associated with occupation, and poor diet. Other responses included heavy drinking, and lack of exercise.

Heart disease, diabetes and chronic illness / disability

Four respondents (3%) reported having had a heart attack (myocardial infarction), and

26% reported that they had a family history (parents, brothers or sisters) of myocardial infarctions under the age of 65. The NHLS 91 study found that 4% of their respondents had suffered a heart attack whilst the 1991 Health Survey for England found that 3% of all adults had suffered a heart attack. When the subjects of my study were asked if they had a long standing illness/health problem, 30% of those who responded positively, identified their problem to be related to heart or circulatory condition. Hypertension is a recognised risk factor associated with heart disease. 15.2% of my respondents reported that they were told by a nurse or a doctor that their blood pressure was higher than normal. 9.6% reported to be taking tablets as treatment for their high blood pressure. Another risk factor associated with heart disease is the level of blood cholesterol. 27.6% of my respondents reported to have had their blood tested for cholesterol level. Of them, 22.5% were told by the doctor or the nurse that their cholesterol was higher than normal. Finally, both smoking and a high BMI are associated with heart disease. The BMI result were reported above. My study found that 25.5% of the respondents smoked daily, 6.7% are occasional smokers and 14.8% are ex-smokers. The mean age for starting smoking was 18.2 years. The mean number of cigarettes smoked per day is 14.5.

Table 8.4: **Heart disease: Risk factors**

RISK FACTOR	GREEK CYPRIOTS	NHLS 91	HSE 91
Hypertension	15.2%	Not included	21%
Blood cholesterol	22.5%	Not included	66%
Smoking	32%	36%	30%

The NHLS 91 study found that the overall prevalence of smoking in Newcastle was 36% which is substantially higher than that reported by the 1991 Health Survey for England (30%). The total of regular and occasional smokers of the GCS 95, falls between the findings of these two studies at is 32.2%.

Four respondents (3%) reported that they were diabetics, which is higher than the

national average. Nabarro (1988) reported that the age adjusted prevalence of clinically diagnosed diabetes (all types) in England ranges between 1.05% and 1.36%. In the NHLS 91 it was reported that 2% of their respondents were suffering from diabetes. The 1991 Health Survey for England also reported a 2% incidence in their adult sample.

When asked if they had a long-term illness, health problem or handicap 28.7% (n=41) answered positively. In the NHLS 91 it was reported that 28% of their respondents suffered from some form of long-term illness with an additional 15% reporting to be suffering from an activity-limiting long-term illness. The HSE 91 reported a 40% incidence of long-standing disability or illness in their sample. Table 8.5 gives the nature of health problem as reported by 40 of the respondents and are compared with the HSE 91. However, the comparison needs to be viewed with caution. The degree of variability between the GCS 95 results and those of the HSE 91, is most likely due to the small numbers of the GCS 95 study (n=40). Because of this factor, there is a greater likelihood that the results of the GCS 95 study may have arisen by chance. Also, the differences in age and gender structure between the two samples may have impacted on the results.

Table 8.5: **Reported long-term illness**

	GCS 95(n=40)		HSE 91(n=3229)	
	%	(N)	%	(N)
Heart or circulatory	30.0%	(12)	11.0%	(355)
musculo-skeletal	17.5%	(7)	17.4%	(561)
respiratory	10.0%	(4)	8.1%	(261)
skin problem	5.0%	(2)	2.0%	(64)
sensory problem	5.0%	(2)	8.2%	(264)
mental health problem	2.5%	(1)	1.5%	(48)
other health problem	27.5%	(11)	11.4%	(368)
cancer	2.5%	(1)	1.3%	(42)

Discussion of findings

Nearly fifty per cent (48.8%) of the women in the study and 35.9% of the men are overweight, which is a worrying statistic, especially when we consider that just over a third of the respondents are smokers (32.2%), almost a quarter (22.5%), of those who

were tested, have been found to have raised cholesterol levels and over 15% have hypertension. Although the incidence of myocardial infarction is similar to that reported by other studies of the general population, the reported incidence of morbidity due to heart or circulatory disease is almost three times higher than that of the rest of the population. It is interesting to note that in 1991 in Cyprus, the morbidity rate from diseases of the circulatory system was 10.6% which was far higher than any other cause. This had risen steadily from 1980 when it was 8.4%. By 1995 the Cyprus department of health, reported that in 1993, 3,142 people were hospitalised with cardiac conditions (approximately 70% were men and 30% were women) and that the main cause of death amongst Greek Cypriots was due to cardiovascular diseases such as ischaemic heart disease and strokes.

With regard to the nature of the other reported long-term illness, these seemed to correlate with the findings of a study into the primary health and contraceptive needs of 93 Greek Cypriot women (Papadopoulos and Worrall 1996), which found that the most frequent cause of ill health was cardiovascular disease. This followed by diseases of the musculo-skeletal system, such as arthritis and backache. Health problems associated with stress such as depression, tiredness, migraines and insomnia, were next in order of reported causes of ill health, and were followed by diseases of the respiratory system mainly asthma. The women who took part in the study (Papadopoulos and Worrall 1996), were asked to state whether, in their view, their health problems were associated with their occupation, past or present. Over a third of them reported positively, stating that sitting on the sewing machine for hours (commonly known as *'machining'*), meant that they took very little exercise and this was the main reason for becoming overweight. In their view, backache, pains in the shoulders and hands are also the result of *'machining'*. The relative isolation of the women who machine at home, may also result in depression. Some of the women also reported that in their view, their asthma was the cumulative effect of breathing the dust and chemicals from the clothes which they machine. With the increase in asthma in the population of the UK, which is commonly thought to have occurred due to atmospheric pollution, many Greek Cypriots who work in the traditional clothing industry, often called *'sweat shops'* because of the poor

environmental and employment conditions, may be at further risk of developing asthma. It may be argued that whilst further studies will need to be undertaken to test this hypothesis, health and local authorities could engage in an awareness campaign to promote health at work and workplace.

The findings of my health and lifestyle survey, reveal a variation in the way men and women define their health and fitness status. There is a marked tendency for the women to perceive these as reasonable (a mid point in the scale used), whereas men's scores are more evenly spread. This may indicate that women appear to be less satisfied with their health and fitness status than men or that they use a different conceptual framework to define health and fitness. Statistical testing revealed that there is a weak association between the way men and women define their health status and that the gender difference in fitness definition is statistically significant. Issues around health values and beliefs which determine how the Greek Cypriots define health and illness, were discussed in Chapter 7.

FOOD

Dietary habits

Respondents were asked to indicate the types of food they ate and how often they consumed it. The majority of respondents (96%) reported that they ate red meat; more than a third of them (34.5%) eat it most days. The frequency of poultry consumption is high (45.5%), whilst the consumption of fish is low, particularly so when it comes to oily fish with 27% of the respondents reporting that they rarely or never eat it. Over fifteen per cent (15.5%) reported to eat fried foods most days. The frequent consumption of cakes, biscuits and hard as opposed to soft cheeses is fairly high at 43% and 43.6%. On the positive side, there is a high consumption of raw vegetables and fruit. On average 75% of the sample reported to be eating these most days.

Table 8.6: **Frequency of consumption of key food groups**

	Most days %	Once a week %	Once/twice a month %	Rarely or never %
Red Meat	34.5	51.7	9.7	4.1
Poultry	45.5	51.0	2.1	1.4
Processed meat	5.8	18.0	28.8	47.5
White fish	7.5	44.9	30.6	16.3
Oily fish	4.3	30.0	38.6	27.1
Rice, Pasta, Purguri	24.6	63.0	10.1	2.2
Raw vegetables	73.6	22.3	1.4	2.7
Boiled vegetables	44.8	43.4	5.6	6.3
Pulses	13.5	58.9	17.7	9.9
Fried foods	15.5	41.9	28.4	14.2
Fruit	77.0	18.2	2.0	2.7
Cakes,biscuits,sweets	43.0	39.4	9.9	7.7
Hard Cheese (hg fat)	43.6	37.6	13.4	5.4
Soft Cheese (low fat)	8.9	22.2	12.6	56.3
Low fat yogurt	20.3	33.1	15.8	30.8
Full fat yogurt	4.3	27.1	31.4	37.1

The results of my survey indicate that Greek Cypriots eat less red meat than the people of Newcastle (34.5% versus 59%) and, rather unexpectedly, also eat less pulses than the people of Newcastle (13.5% versus 41%). The consumption of fried foods in the NHLS 91 study appears to be twice the level of that in the Greek Cypriot population in my study (34% versus 15.5%). Both studies found a high consumption of fruit and vegetables and low consumption of fish, particularly the oily type.

Respondents were particularly asked to report the frequency of consumptions of bread, butter/margarine milk and eggs. The findings suggest that the Greek Cypriots in my study eat more white bread than the sample population in the Newcastle study, but they consume considerably less butter and more polyunsaturated margarine, less full fat milk and more semi-skimmed.

Table 8.7: **Foods eaten most frequently**

	GCS 95	NHLS 91
	%	%
White bread / crackers / pitta	65.5	52.0
Wholemeal bread / crackers / pitta	32.4	47.0
Don't eat bread	2.1	1.0
Butter	7.6	20.0
Hard margarine	3.4	Not reported
Polyunsaturated margarine	64.8	40.0
Low fat spread	17.9	17.0
Don't eat butter or margarine	6.2	8.0
Whole / full cream milk	28.0	34.0
Semi-skimmed	60.6	51.0
Skimmed	9.1	10.0
Don't drink milk	2.3	5.0
Eggs per week	0-15 eggs (average 2.5)	Not reported

The participants were asked if they eat traditional Greek foods like keftedes (fried meat balls) sheftalia (type of sausage made with minced meat and wrapped in animal intestinal membrane which is normally quite fatty), kebabs, moussaka -all foods rich in animal fat-, and traditional vegetarian dishes such as fasolia (beans), louvi (black eye peas), and soups, and if they do, how often do they eat these foods. Figure 8.13 and Figure 8.14 report the findings. Over eighty seven per cent of the respondents (87.7%) reported that they eat the traditional meat dishes often or very often and 89.8% reported that they eat the traditional vegetarian dishes often or very often.

Fig 8.13 : **Frequency of eating traditional meat dishes**

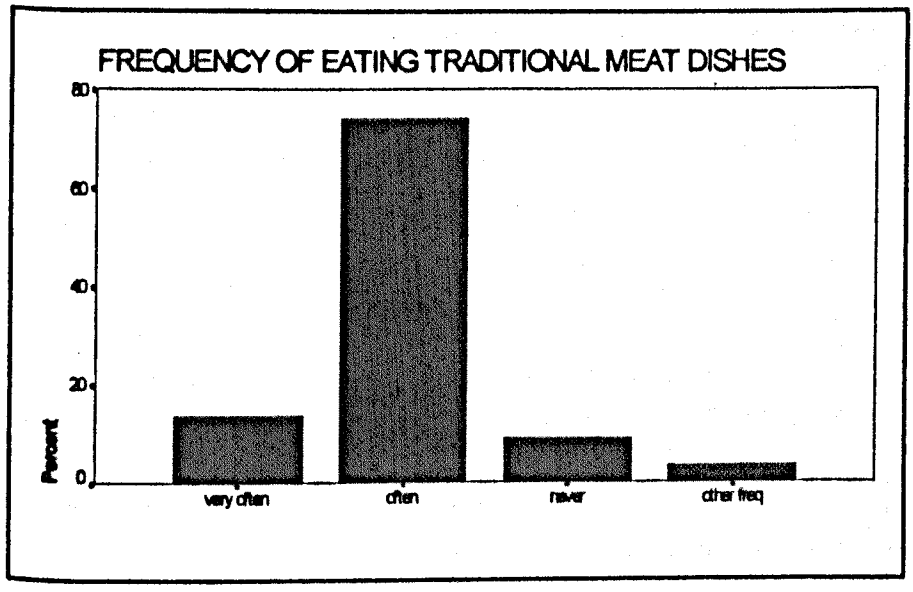
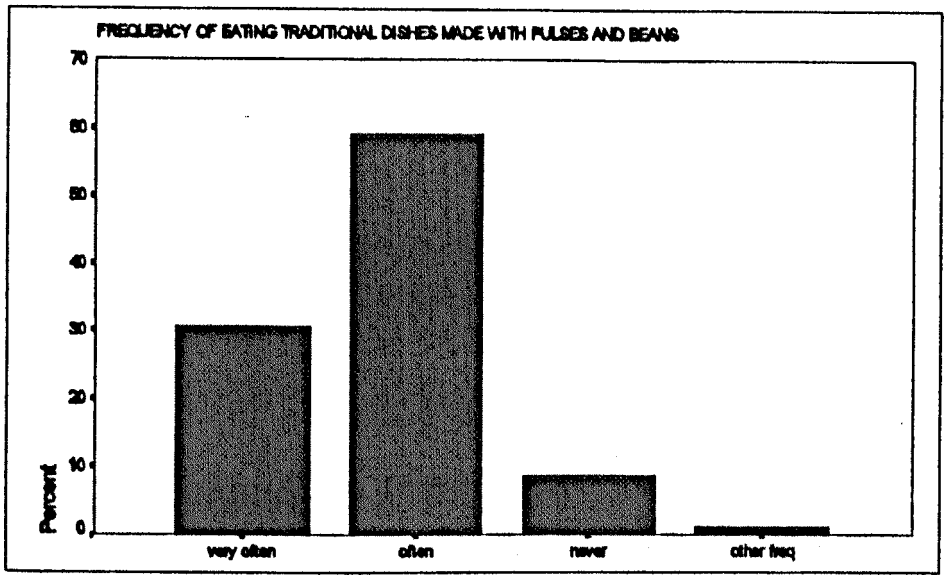


Fig 8.14: **Frequency of eating traditional vegetarian dishes**



In order to summarise the different elements of diet and relate these to recommended dietary intake, the food data were recoded to derive a dietary behaviour score. The method of scoring is based on the broadly accepted recommendations that a healthy diet should be low in fat, sugar and salt, and high in fibre (DHSS 1984, HEA 1991). This revealed that more women are *'healthy eaters'* than men (51% versus 38%). There was a statistically significant association between healthy eating and being over 55 years in age ($p=<.01$). More first generation than second generation respondents were *'healthy eaters'* (56% versus 35%); this was expected bearing in mind that all the over 55s belonged to this group. It seems that healthy eating may be related to the traditional Greek diet but unfortunately I was unable to test this hypothesis due to not having any over 55 year olds who belonged to the second generation in my sample. Healthy eating was not related to income nor to education. However, the best knowledge about food was possessed by those in the 35-54 years age group from both first and second generation, whilst the over 55s appear to know the least. Finally, it is interesting to note that more women than men gained higher food knowledge scores, although this was not statistically significant.

The NHLS 91 also found that women were more likely to be 'healthy eaters' than men, but the age group was lower (45-54 years). They also found that those with higher

income, in work, and with higher education tended to be 'more healthy eaters'.

Changes in diet

Respondents were asked whether they had changed their dietary habits during the previous year and if they had, what was the reason. Just over twenty three per cent (23.3%) responded positively. The main reason for the change was to improve their health (35.7%) followed by the desire to improve their appearance (32.1%), for medical reasons (21.4%), and a variety of other reasons (10.7%). When asked if they thought they were eating a healthy diet, 68.8% reported that they do.

The NHLS 91 reported that 28% of their respondents had changed to a more healthy diet compared to what they were eating in the previous year.

Discussion of findings

It is generally reported that the *'Mediterranean'* diet, in which the Greek Cypriot diet belongs, is a healthy diet. The traditional Greek and Greek Cypriot diet, was basically a vegetarian diet with high consumption of raw vegetables and fruits, potatoes, pulses and cereals. It needs to be remembered that Cyprus was, until the 1960's, an agricultural country. Animal farming was less common; sheep, goats and cows were kept to provide milk for daily consumption and for cheese making. Meat was expensive to buy and most families would eat it usually once or twice a week, mainly on Sundays. With the arrival of tourism and other industries in the last 30 years, more people have found full and better paid employment and therefore have been able to raise their standard of living; an important indicator of *'doing well'* was both the increase of meat in the diet and a general increase of the volume of all foods. These changes have resulted in heart disease of epidemic proportions. This is confirmed by the 1991 Cyprus *'Health and Hospital Statistics'* and the 1995 report from the Cypriot department of medical services and public health. In August 1995, Nikos Tokas reported in the *'Parikiaki'* , the Greek Cypriot newspaper of the community in the UK, that according to the president of the Cypriot cardiac society, 2000 Greek Cypriots die every year from heart disease, whilst 600 Greek Cypriots are sent abroad to have cardiac surgery, costing the government

millions of pounds; and all these, for a country with a population of around 600,000. A common saying in Cyprus which reflects the realisation of the people that this is a negative and dangerous change is : ***'We work as though we'll live for ever and we eat as though we'll die tomorrow'.*** Most of the respondents in my study would hold similar values about food to those held by their compatriots living in Cyprus. The findings of my study, indicate that although more than two thirds of the respondents think that they eat a healthy diet, perhaps because they eat plenty of vegetables and fruit, their consumption of red meat, cakes and hard cheeses is too high. This finding helps to explain the previous finding that almost 50% of women and 36% of men are either slightly overweight or obese.

These findings may also indicate that it is not helpful to talk in blanket terms about how good or bad particular diets are. The meaning of a *'Mediterranean diet'* for a food scientist, a TV cook, a nurse, a Greek Cypriot, an Italian, and so on may differ enormously, yet the generalisation that is often made in the popular press, is that the *'Mediterranean diet'* is healthy. The danger is, that both health professionals and people such as the Greek Cypriots, pay less attention to this very important area of health behaviour. It is worth noting that one of the Department of Health's target included in the *'Health of the Nation'* strategy, is that by the year 2005, the proportion of obese men should be 6% and that of obese women only 8%, of the population. Unless urgent and drastic action is taken, it is very doubtful that these targets will be achieved.

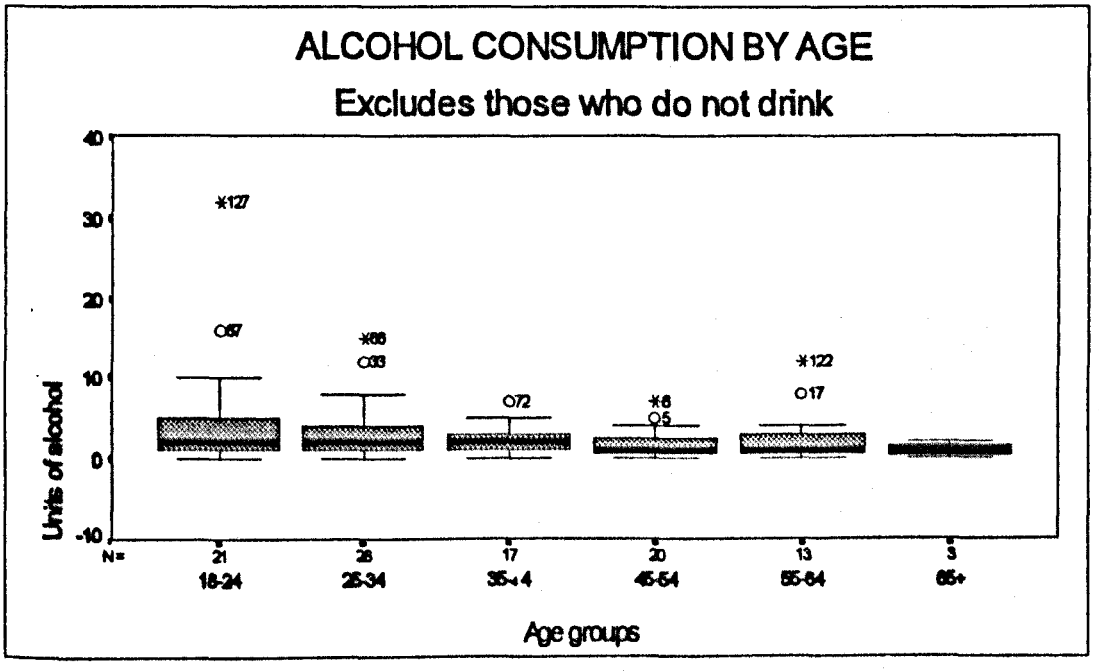
ALCOHOL

Alcohol consumption

Twenty six respondents (17.4%) reported that they never drank alcohol and 8.7% (n=13) that they used to but no longer drink alcohol. The vast majority (59%, n=88) of informants drink alcohol at about once a week and less than twice a month. A total of 14.8% (n=22) reported to consume alcohol between twice a week and every day. Ninety eight respondents (89.1% of those who drink alcohol) rated themselves as light drinkers and 10.9% (n=12) rated themselves as moderate drinkers. Nobody rated him/herself as

heavy drinkers. When asked to report how many units of alcohol they consumed in a typical week including the weekend (using the 1992 HEA standard drink table), 95% of those who responded (n=97) reported to drink between 0-10 units of alcohol. Only five respondents (5%) said they were drinking between 12-32 units. Figure 8.15 gives details of alcohol consumption by age. When asked if they thought their current level of alcohol consumption is harmful to their health, three respondents answered affirmatively (2.7%) and 107 (97.3%) answered negatively. Similarly 95.5% (n=85) did not wish to change their present level of alcohol consumption.

Fig 8.15: **Alcohol consumption by age**



In the NLHS 91 study 82% of the participants reported drinking alcohol. 44% drank alcohol at least twice per week. 77% of the respondents were found to be drinking within safe limits, 20% fell into the *"increasing risk"* category and 3% as *"hazardous"*. Most people (84%) were happy with their present level of drinking alcohol, 12% wanted to drink less 3% wanted to stop altogether and 1% said they would like to drink more.

The HSE 91 that 91% of their sample drank alcohol. 7% of men and 5% of women who drank were classified as problem drinkers. Over half (51%) of men and 42% of women

who were current drinkers said that they had cut down the amount they drank compared to five years ago. Only 5% of men and 4% of women had cut down because of their health.

Respondents were asked to state what were the safe alcohol limits for men and women. The ranges given for men were 0-100 units, the mean being 9.9 units of alcohol. The ranges given for women were 0-50 units, the mean being 7.6 units of alcohol.

Discussion on findings

The findings of my study, are in stark contrast to the findings by Theodorou (1992); in her study of 160 interviews of Cypriots (Greek and Turkish) carried out in North London, she found that the level of harmful consumption (over 35 units per week) in the Cypriot community is considerably higher than that of the overall population. She found that 48.8% of the men and 12.6% of the women in the sample, drank more than 35 units per week. This may be explained by the fact that she used a '*snowball*' sample, whereas mine was a random sample. Theodorou (1992), used semi-structured interviews to obtain her data, whereas I used a postal questionnaire. Methodological problems and biases associated with these methods of data collection are well documented. Another study is needed to confirm or refute either of these findings in order to enable health providers and purchasers make appropriate decisions.

The lack of knowledge about safe alcohol limits - revealed by this study- is of some concern and points towards the need for more appropriate ways of information giving, by all those involved in health promotion.

ACTIVITY AT WORK AND LEISURE

Level, type of activity and attitudes about physical exercise

Respondents were asked to describe the type and level of physical activity which they undertook on a daily basis either at work or at home. A large proportion, 42.9% (n=60) reported that they are *'usually sitting and do not walk about much'*, whilst a slightly

smaller percentage, 38.6% (n=54), reported that they *'stand or walk quite a lot but their work or housework does not involve heavy lifting'*. An even smaller number, 15% (n=21), reported that they *'usually lift or carry light loads and that they climb stairs often'*, and finally 3.6% (n=5) reported that they *'do heavy work or carry heavy loads often'*.

Subjects were given a table of leisure activities which contained a list of light activities (eg walking, light gardening), a list of moderate (eg swimming, jogging) and a list of strenuous leisure activities (eg competitive running, football), and were asked to indicate how many times in the previous two weeks they had taken part in light, moderate or strenuous activity which lasted for more than twenty minutes. One hundred and thirty five (n=135) people reported that they undertook some light physical activity for up to 50 times per week, the mean being 6.37 times. Some 137 people also reported that they undertook moderate physical activity up to 12 times per week, the mean being 1.61 times. One hundred and seven (n=107) reported that they had not undertaken any strenuous leisure activity in the previous two weeks. Twenty two (n=22) reported to have undertaken such activity between one (1) and five (5) times, six (n=6) reported to have undertaken strenuous leisure activity between six (6) and ten (10) times and two (n=2) reported this to be more than ten (10) times.

In order to assess the levels of activity of my sample, activity scales were constructed. These scales replicate those of the Allied Dunbar Fitness Survey (ADNFS) (The Sports Council and the HEA 1992). The ADNFS recommended that individuals should participate in at least three sessions of a mix of moderate and vigorous activity per week, each lasting a minimum of twenty minutes to confer cardio-vascular benefits. The scales used in this survey replicated those of the ADNFS but have been adjusted to a two week period (Table 8.8).

Table 8.8: **Activity level scales based on activity in previous two weeks**

Level 5: Six or more occasions of vigorous activity
Level 4: Six or more occasions mixed between moderate and vigorous activity
Level 3: Six or more occasions of moderate activity
Level 2: Three to five occasions of mixed moderate or vigorous activity
Level 1: One or two occasions of mixed moderate or vigorous activity
Level 0: No occasions of moderate or vigorous activity

Of the 139 cases for whom data was available only 14 (10%) achieved their target activity level as defined by ADNFS. There was no correlation between the sexes as to whether they reached their target level. However, reaching one's target level was correlated with age. More of the 18-34 year olds reached their target level (n= 9 out of 58) compared with those in the 35-54 age group (n=3 out of 53) and those in the 55+ age group (n=2 out of 28). Of those who reached their target level, 71% said their fitness was good or very good compared to only 32% of those who did not reach their target level (p=<.05). None of those who described their health as reasonable, poor or very poor, reached their target level compare to 12% of those who described their health as good or very good (p=0.19).

Asked whether they felt they took enough exercise for someone of their age, forty eight (n=48) responded with *'yes'*, and one hundred and two (n=102) responded with *'no'*. Those who responded negatively were asked to state the reasons which prevented them from taking more exercise. The results are presented in Table 8.9.

Table 8.9: **Reasons preventing respondents from taking more exercise**

	(N)*
Lack of time	63
Lack of motivation	43
Lack of money	28
Illness or disability	17
Lack of transport	12
Lack of accessible facilities at work	11
Lack of accessible facilities in the community	11
Other reasons	9

* *Respondents could tick more than one box*

Participants were asked to compare their current levels of activity with the levels of the

previous year. Of those who responded, 18.6% (n=26) stated that they are now more active; 60% (n=84) stated that their activity levels are the same and 20.7% (n=29) reported no change.

The two top reasons cited in table 8.9 were analysed further. I discovered that more of those who were fully occupied (in full employment, self employed, on a government employment scheme, and those looking after home and children under the age of 16), gave *'lack of time'* as their reason for not taking more exercise, as compared with those who were not fully occupied (working less than 30 hours per week, waiting to start a job, unemployed, full time students) (69% versus 48%, p=<.05). More men than women said they *'lacked motivation'* (53% versus 33%, p=<.05). More of those who were fully occupied (definition as above) also reported lack of motivation compared to those not fully occupied (51% versus 29%, p=<.05); it was also found that the over 55 year olds were more likely to cite lack of motivation as a reason for not taking more exercise. However, there was no association between marital status and lack of motivation and this was irrespective of generation.

Asked if they would like to do more exercise and what type of activities they would most like to take part, forty seven (n=47) people reported that they would like to undertake a variety of activities such as aerobics, weight lifting, other gym activities etc, forty three (n=43) respondents stated that they would like to take part or do more swimming, thirty two (n=32) would like to partake in more outdoor sports such as walking and cycling, sixteen (n=16) wished to be involved with football, tennis and badminton.

In order to account for levels of activity that respondents engaged in at work or during usual (non-leisure) day time activities, a new variable was constructed which combined this activity and the leisure time activities. Those who reported that they usually sit and do not walk much were assigned a score of 0 (see activity level scales, Table 8.8), those who reported that they stand or walk about quite a lot but do not carry or lift things were assigned a score of 2. Those whose work involved climbing often and/or lifting

light loads were assigned a score of 3 , those whose work involved heavy work or carrying heavy loads were assigned a score of 4. The activity scale was divided into three categories: *'sedentary'*: a maximum of one or two occasions of moderate or vigorous activity (levels 0 and 1), *'active'* (three to five occasions of mixed moderate and vigorous activity or six occasions of moderate but not vigorous activity (levels 2 and 3) and *'very active'* (levels 4 and 5: six or more occasions of mixed moderate and vigorous activity). Table 8.10 below gives the results of this combined activity level for all those for whom data were available (n=129). It points out that 60.5% of the respondents were found to be sedentary which is a worrying statistic.

Table 8.10: **Combined activity level scores**

Category	**N**	**%**
Sedentary	78	60.5
Active	34	26.4
Very active	17	13.2

The most sedentary were found to be the over 55 year olds (69% versus 67% of those aged 34-54, and 50% of those aged 18-34, p=<.05). More women than men were found to be sedentary (64% versus 54%, p=<.05). Those with a chronic illness or disability were also more likely to be sedentary as compared those who did not report having a chronic illness (78% versus 54%, p=<.05). A small correlation was found between being overweight and leading a sedentary life (65% versus 58% of those not overweight) but this was not statistically significant. There was no association between education and combined level of activity.

Participants were asked to express their opinions on ten (10) statements about exercise. The results from those who responded (n=147) are reported in Table 8.11 below.

Table 8.11: **Respondents views about exercise**

	Agree %	Not sure %	Disagree %
Vigorous exercise can be dangerous if you are not used to it	78.9	19.0	2.1
Sport is only for fit, young people	12.7	15.5	71.8
Regular exercise is important if you want to lose weight	80.4	16.1	3.5
Exercising outdoors is better for you than exercising indoors	31.0	34.5	34.5
Regular exercise can help reduce your risk of heart disease	81.5	15.8	2.7
You need a lot of expensive equipment to get fit	4.3	10.7	85.0
Regular exercise makes you look more masculine	14.0	28.0	58.0
A short walk a day is better than no exercise at all	90.5	6.8	2.7
Pregnant women should not exercise	7.6	31.0	61.4
You can't get fit on your own	9.2	18.3	72.5

In order to measure the participants' knowledge about exercise all the above views (with the exception of *'regular exercise makes you look more masculine'*) were given a score of 3 for the correct response, a score of 2 for *'not sure/it depends'* and a score of 1 for the incorrect response. Although overall, the Greek Cypriots appear to have a fairly good knowledge about exercise, the results showed that individuals from the first generation and those who were aged 55 and over, had the lowest knowledge. There was no difference between the sexes. Those scoring high tended to be those with college and university education. However, a good knowledge about exercise did not result in higher levels of activity and there was no association between good knowledge and the achievement of target level of exercise. Good knowledge did not result in better motivation for more activity.

The NHLS 91 reported that overall only 12% of men and 3% of women achieved their activity target level. Achievement of target level was associated with higher income and perceived fitness. Of the 41% who thought they took enough exercise for their age, only 13% had actually achieved their target levels. Of those who thought they were not taking enough exercise, 43% said that this was due to lack of time, 38% due to lack of motivation and 27% due to lack of money.

The HSE 91 reported that overall 20% of men and 12% of women reached activity level 4 and 5 and 29% of men and 30% of women reached level 3. Informants with higher education were more likely to achieve levels 4 and 5. Conversely, heavy smokers, obese

people, occasional and non-drinkers, were least likely to achieve levels 4 and 5. None of these associations were found to exist for achieving the lower levels.

Discussion of findings

The Royal College of Physicians (1991), reported that regular exercise helps reduce the risk of heart disease, helps control mild hypertension and protects against the onset of osteoporosis in women. Steinberg and Sykes (1993) also found that exercise is beneficial to mental health. Various reports published between 1953 and 1985 and reviewed by Powell et al (1987), show an association between high levels of physical activity and low incidence of coronary heart disease among men, and a number of studies since 1985 have confirmed this association. As a result, it has been suggested that physical inactivity may be more important than other risk factors such as cholesterol, blood pressure and smoking. There is also some evidence that women with high activity levels have lower rates of heart disease, but studies of women have generally been less conclusive (Lapidus and Bengtssen 1986).

Probably the most significant findings from my study are that 60% of the sample lead sedentary lives and that only 10% of them achieved their target activity level. The women, the overweight, the over 55 year olds, the first generation Greek Cypriots, and those who suffer from a chronic illness appear to be the most at risk. The findings pointed towards an association between lower levels of activity and knowledge, and individuals who were classified as first generation. My findings are worse than the national average as reported by the *'Health Survey for England 1994'* which found that just under 18% of their sample were classified as inactive or sedentary. Clearly this is an area which merits further investigation among the Greek Cypriot community.

SMOKING

Smoking behaviour, knowledge about harm and attitudes about smoking

As mentioned earlier, a total of 32.2% of my respondents reported to be smokers. Of them 25% stated that they smoke daily, and 7% occasionally. 15% reported to be ex-

smokers, but a 53% majority had never smoked. The age for starting smoking ranged between 9years and 38years. Those who smoked daily smoked between 2 and 30 cigarettes, or 0-17 cigars, or 0-0.2 ounces of tobacco. Informants were asked whether they would like to alter their smoking behaviour; 32.6% reported that they were happy to stay smoking the same amount, 21.7% would like to cut down a bit, 8.7% would like to cut down a lot, and 37% wished to give it up altogether. The findings did not reveal any correlations between smoking and age, levels of stress, levels of alcohol consumption, education or level of exercise.

The NHLS 91 found that a total of 36% of their informants were smokers and 36% non-smokers. Of the regular smokers 31% smoked daily and 5% occasionally. Age for starting smoking ranged from 5 years to 55 years. Of the smokers 26% reported that they would like to reduce the amount they smoked and 50% said they wished to stop completely.

Respondents of my study were asked whether they thought the amount they smoke is harmful to their health. 78.3% responded positively and 21.7% negatively. They were also asked whether they had, in the previous 12 months, made a serious attempt to give up smoking. 26.7% answered positively and 73.3% negatively. Those who tried to stop reported that they started again because they lacked the will power (30%), they were stressed or bored (20%) and for other reasons (50%). However, 47.7% reported that they had cut down the amount they smoked during the previous 12 months.

Forty two per cent (42%) of the participants in the NHLS 91 study reported that they had made a serious attempt to give up smoking in the previous year. The most commonly reported reasons for starting to smoke again were *'feeling irritable'* (24%), *'feeling stressed or bored'* (22%), *'no will-power'* (14%).

The HSE 91 reported that 25% of men and 31% of women in their sample who were smoking, had tried to give up smoking because of their health.

Table 8.12: **Ex-smokers' reasons for giving up smoking**

	GCS95			NHLS 91		
	Very Important %	Fairly Important %	Not Important %	Very Important %	Fairly Important %	Not Important %
Felt it was bad for own health	100.0	–	–	87	9	4
Costing too much money	26.3	36.8	36.8	43	30	27
Advice from a doctor or nurse	58.8	11.8	29.4	34	16	50
Pressure from family or friends	35.3	17.6	47.1	27	22	51
Felt it was antisocial	14.3	42.9	42.9	24	29	47
Not allowed to smoke at work	–	7.1	92.9	8	6	86

In answer to the question *'do any of the members of your household smoke'*, 50.3% (n=74) of those who responded reported positively, and 49.7% (n=73) responded negatively. Of those who answered positively fifty six (n=56) reported that there was one (1) member of the household who smoked, ten (n=10) reported that two (2) members smoked, four (n=4) that three (3) members smoked and two (n=2) reported that four (4) members of their household smoked.

Respondents were asked to indicate how many cigarettes a day would a person have to smoke before risking their health. The answer of the majority of the respondents (n=60) was between 1 and 5 cigarettes. Thirty one (n=31) reported this to be between 6 and 10 cigarettes and almost as many (n=28) thought that one had to smoke between 11 and 20 cigarettes before risking their health. A further fifteen (n=15) thought that one would need to smoke 21-30 cigarettes per day before risking his/her health and the remainder eight (n=8) reported this to be 31 and over cigarettes per day.

Participants were asked to express their views on a number of statements related to smoking restrictions. The results are in table 8.13 below.

Table 8.13: **Respondents views about smoking restrictions**

	More restrictions	About the same	Fewer restrictions
	%	%	%
On buses	58.5	36.1	5.4
On trains	60.5	35.4	4.1
On aeroplanes	67.1	26.6	6.3
In restaurants and cafes	59.6	33.6	6.8
In cinemas and theatres	59.7	32.6	7.6
In banks and post offices	63.2	33.3	3.5
In all shops	63.4	31.7	4.8
In public houses	52.8	37.5	9.7
In hospitals and clinics	74.7	20.5	4.8
In all enclosed public places	71.0	23.4	5.5
In all public places	49.7	39.2	11.2
In the place where you work or study	60.0	32.4	7.6

Participants were asked to say whether or not the smoke from cigarettes could be harmful to the health of non-smokers who breathe it regularly. Of those who responded, one hundred and thirty one (n=131) reported that passive smoking was harmful to adults, whilst one hundred and forty four (n=144) said that this was harmful to children and babies.

Discussion of findings

The Health Education Authority (HEA 1994) reported that the highest smoking prevalence amongst minority ethnic groups (African-Caribbean, Indian, Pakistani and Bangladeshi) was that of the Banlgadeshis at 23%. As already discussed in section 2, smoking is one of the major risk factors for heart disease. The findings of my study show that compared with the whole population in England, smoking in the Greek Cypriot community is higher by 2% and by 9% compared with other minority ethnic groups. Judging by their various responses the Greek Cypriot smokers realise that both active and passive smoking are harmful to health. However there appears to be a dissonance between their beliefs and their actions or behaviours. It is of concern that as many as a third of those who responded thought that one would need to smoke between 21-30 cigarettes per day before risking their health and that only just over a quarter of the respondents attempted to give it up, the majority of whom were unsuccessful. Advice from a health professional seems to be the most significant deterrent, but as can be seen in this chapter, the health professionals are failing to provide this most crucial advice.

The Department of Health (DoH 1992) has set a number of targets in its *'Health of the Nation'* strategy which need to be achieved by the year 2000. One of these is to reduce the prevalence of cigarette smoking to no more than 20% by the year 2000 in both men and women. The findings of this survey suggest that unless urgent and co-ordinated action is taken using the *'healthy alliance model'* (involvement of statutory health and social services sectors as well as the voluntary sector), it is highly unlikely that the DoH targets on smoking will be achieved within the Greek Cypriot community.

STRESS

Stress levels, stressors and stress reducing strategies

Respondents were asked to indicate how stressful their lives were at the time of completing the questionnaire. A 10 point scale was used with the score of 1 being *'not at all stressful'* and 10 as *'very stressful'*. Twenty one per cent (21%) of the sample reported that their lives were relatively stressless by scoring 1-4; some 16% rated their stress at level 5, the mid point of the scale which indicated that they are fairly stressed. The overwhelming majority (64%), reported to be under a lot of stress by rating their stress between 6 and 10.

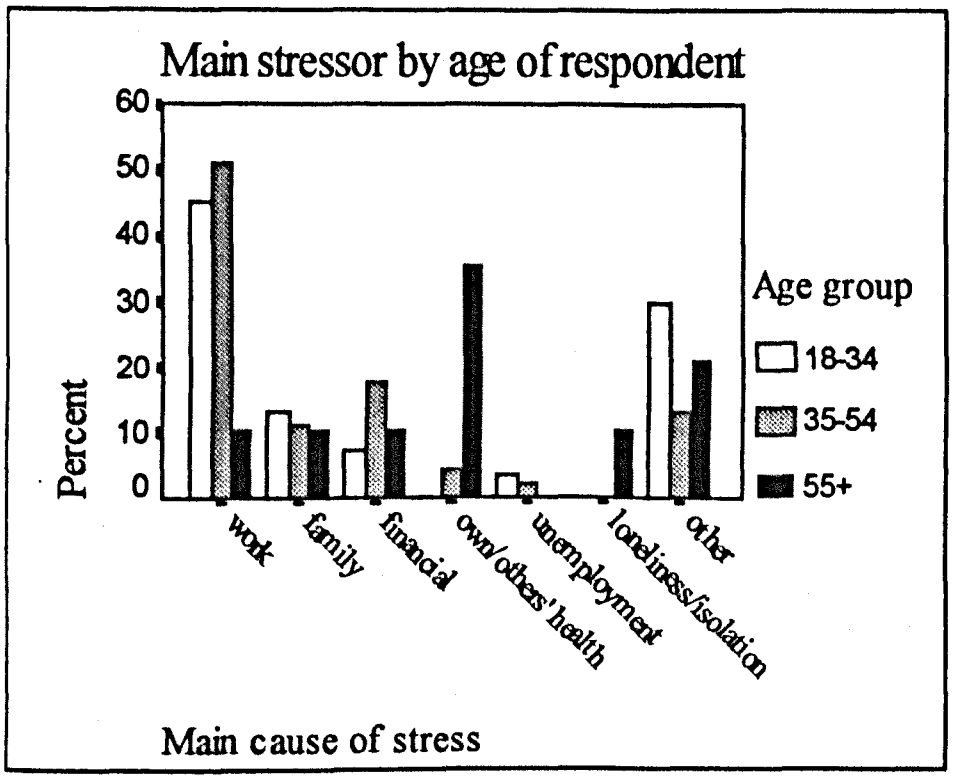
The ten point stress level scale was dichotomised at level 6; level 1-5 was assigned as *'low'* stress and 6+ as *'high'*. This new variable was used to explore differences in stress levels between age groups and men and women. There was no relationship found between stress level and gender but there were differences between age groups: Lower proportions of those aged 55+ were found to have high stress levels (41% versus 70% of those aged 35-54, and 68% of those age 18-34, $p=<.05$). Level of stress was also cross tabulated with a number of other variables: reported income, social activity, health perceptions, marital status whether they had children or not, whether fully occupied or not, and generation of the respondents. These were not found to be associated or if they were, the findings were not statistically significant. However, there was an association between stress level and level of happiness: 83% of those who were unhappy had high stress levels (6+) compared with 52% of those who described themselves as *'happy/ very*

happy' (p=<.01).

Participants were asked to list their three greatest causes of stress in descending order of magnitude. Work was most frequently cited as the respondents' greatest cause of stress (40%) followed by family (12%) and financial problems (12%). Ten per cent cited their own health or the health of others as their greatest cause of stress. Unemployment and loneliness were cited by 5% of the respondents. The second greatest causes of stress respondents reported were family issues or problems (25%), financial concerns (20%), work (11%), own health or health of others (8%), and unemployment, loneliness and isolation (5%). A number of other specific reasons, too many to form categories, were given.

The data on stressors were explored for differences between men and women and age groups. There was no association found between gender and stressors but a moderate association was found between age and type of stressor. As figure 8.16 illustrates, Those aged under 55+ gave work as their greatest cause of stress, whereas those aged 55+ most frequently gave their own health or the health of others as their greatest cause of stress. Family concerns were equally spread throughout the age groups whereas financial concerns were greater among those aged 35-54. Loneliness or isolation was cited as the greatest cause of stress only by those who were aged 55+ (p=<.001).

Fig 8.16: **Greatest causes of stress by age groups**



Participants were asked their views about a number of behaviours which are commonly cited as 'stress reducers' or responses to high levels of stress. Table 8.14 summarises their responses.

Table 8.14: **Opinions of respondents on a number of behaviours and their effectiveness in reducing stress**

	Very effective %	Fairly effective %	Not at all effective %
Trying to forget your problems	24.1	40.9	35.0
Resting and relaxing	55.9	40.0	4.1
Having a few drinks	10.2	36.5	53.3
Having a cigarette	11.0	23.5	65.4
Visiting the doctor	4.3	35.5	60.1
Taking some exercise	34.0	48.2	17.7
Eating more	7.4	14.7	77.9
Taking tablets	7.3	20.4	72.3
Spending money	13.9	29.9	56.2
Discussing the problem with another person	52.1	37.5	10.4

When the results from the *'very effective'* and *'fairly effective'* categories were combined, it was interesting to note that the respondents believed that the most effective ways for dealing with stress were: *'resting and relaxing'* (96%), and *'discussing the problem with another person'* (90%), *'taking some exercise'* (82%) and *'trying to forget your problems'* (65%). The least effective ways for reducing stress were *'eating more'* (78%), *'taking tablets'* (72%), *'having a cigarette'* (65%) and *'visiting the doctor'* (60%). Further analysis of the data was undertaken to explore the relationships between the stress reduction strategies (as listed in Table 8.14) where most variance in response existed, and age and gender. The findings are as follows: those who were aged 55+ more frequently stated that trying to forget your problems is an effective stress reducing strategy (87% versus 68% of those aged 35-54 and 51% of those aged 18-34, p=<.05). This was not associated with gender. *'Having a few drinks'* as a effective stress reduction strategy was not associated with age of respondent but there was a small association between this and gender: more males agreed with this statement (55% versus 42%, p=.13). *'Having a cigarette'* was more likely to be seen as an effective strategy by those aged under 55 (p=.059) and by males although this association was not quite statistically significant (p=.16). More of those aged 55+ saw *'visiting the doctor'* as an effective strategy (64% versus 39% of those aged 35-54 and 29% of those aged 18-34, p=<.01) but this was not associated with gender. Those aged 35-54 more frequently reported that *'eating more'* was an effective strategy (32% versus 19% of those aged 18-34 and 11% of those age 55+, p=.07), no association was found with gender. *'Taking tablets'* was seen to be an effective strategy more frequently by those aged 55+ (44% versus 33% of those aged 35-54 and 15% of those aged 18-34, p=<.05), there was no association with gender. *'Spending money'* was more likely to be seen as effective by the youngest age group (62% versus 38% of those aged 35-54 and only 14% of those aged 55+, p=<.001) and by women (48% versus 36%, p=.16).

Discussion of findings

Stress has, for many years, been established as a contributory factor to both physical and mental illness. In 1995 the Health of the Nation publication *"Variations in Health. What can the Department of Health and the NHS do?"* states that ethnic minority groups may

experience high levels of stress due to language difficulties and racial discrimination in housing, education and employment and that this indeed contributes to poor mental wellbeing and excess risks of coronary heart disease.

The respondents in this study have reported high levels of stress due mainly to work, family and financial reasons. The higher stress levels reported by those in the age group of 18 -34 years and 35-54 years may be due to these age group experiencing the whole range of *'work profile'*. For example, those at the lower end of the age scale would probably be trying to enter the work market and may be finding this difficult, or if they have already gained employment they may be trying to adjust to new life patterns and relationships. Those in the middle of the age scale, may have found themselves in dead end, poorly paid jobs and may be facing economic difficulties, having to support a family. As reported, 75% (of those who provided data about their income) had a net personal income of up to £8,000 per annum. Those at the top end of the age scale may be facing redundancy or more likely for a Greek Cypriot man, bankruptcy. It is quite possible that many Greek Cypriots encounter discrimination and racism when seeking employment or when at work. All these work scenarios would also explain the financial difficulties and even the family problems.

Another explanation for the high stress levels being attributed to family, may be that of the generation gaps. It is likely that many of the *'parents'* in my study would be first generation Greek/Greek Cypriots, who hold different values from their children. Family problems may also be the result of changing roles between husband and wife. Both these issues were discussed in Chapter 7. Anthias (1992) has also suggested that Greek men still expect their wives to clean the house, do the laundry, cook the dinner, look after the children and even the friends and relatives who will call or visit from Cyprus, as well as going to work or working from home. It may be speculated that family circumstances and changes in traditions, may sometimes be forcing couples to realise that the expectations they have from each other do not match and this may result in conflict and raised levels of stress.

Those in the 55+ age group, reported that their own health and that of others as well as loneliness and isolation, are major stressors. This finding partly confirms Anthias's (1988) earlier observation. She wrote *"For the elderly, loneliness and isolation feature in a country where many have not been able to learn the language. The Cypriot tradition of parents living near their children and being cared for by them has been dissipated, particularly in London where the majority of Cypriots live"* (p14). Long term illness is more frequent with advancing age and this compounds the anxieties associated with isolation and loneliness.

In a study in South London, Mavreas and Bebbington (1987) found that *'minor'* psychological problems were more common among Greek Cypriots than among the English natives. Andreou's study (1986) in Enfield, suggested that a large proportion of Cypriots (75% of her sample were Greek and 25% were Turkish), experienced anxiety or depression but did not offer explanation regarding the causation of these mental health problems. However, she found that most people sought help from friends and neighbours (60.4%) and only 28.3% sought help from their General Practitioner (GP). She found that individuals were reluctant to use the professional services because they lacked cultural understanding thus they were often unsympathetic to their needs. Ten years on, the results of my study indicate that the second most preferred method of dealing with stress is by discussing the problem with another person (not the GP). Although only 2.5% of my sample reported to be suffering from mental health problems, a large number of them (27.5%) reported a variety of physical health problems many of which may be stress related. As can be seen in a subsequent section of this chapter, Greek Cypriots believe that stress is a contributory factor to many physical illnesses.

Fernando (1991) explains that coping with stress is related to cultural values, and that coping practices cannot be considered in isolation from culture. In Western psychology, coping with stress is usually perceived in behavioural terms, consisting of cognitive processes, such as denial, repression and intellectualisation. This however, ignores the cultural context in which coping occurs and the way coping is perceived and judged in a racist milieu. Therefore culture plays a large part in determining the way in which a

particular event of emotional distress is conceptualised, for example, whether it is seen as *'illness'* to be cured or endured (coping), or as a spiritual crisis to be resolved or experienced (understanding). Coping strategies have been categorised by Folkman and Lazarus (1988) as *'problem-focused'* and *'emotion-focused'*; the former is geared to resolving the problem and the latter directed at reducing distress, irrespective of its underlying cause. Both forms of coping are necessary, but the effectiveness of coping in any given situation depends on the appropriateness of the choice between the two. Greek and Greek Cypriots are regarded as *'Southern European'* or *'Mediterranean'* and are therefore usually excluded from discussions on ethnic health. Littlewood (1988) makes the point that the mental health of the Greek communities in Britain has never been a major issue of concern for the medical profession or for the social services. The emphasis in research and in service provision has always been with *'New Commonwealth'* immigrants and their families, which if strictly interpreted of course includes Cypriots, but which in practice often encompasses only the Black ethnic minorities, whom British society has regarded as having the greatest difficulties in settling and living here. However, whilst Greek and Greek Cypriots base many of their conceptual and ideological frameworks on *'Western'* foundations, those living in Britain share with Black groups many difficulties and characteristics such as language problems, their own unique cultural ideologies and practices, experiences of racism/discrimination, problems of identity particularly amongst the second and subsequent generations and so on.

Constantinides (1988) identified an urgent need for information on the epidemiology of mental health and stress -related illness in the Greek communities; this need still exists in 1996, and service planning continues to largely take place in a vacuum. Furthermore, it may be argued that GPs and hospital staff need educating on issues specifically affecting the Greek communities.

HOME, FAMILY AND SOCIAL LIFE

Social support systems

Respondents were asked to say whether they had anyone they could count on when they

needed to talk over problems or make difficult decisions. Eighty six per cent (86%) reported they did indeed have someone. More women reported having a confidante (93% versus 75%, p=<.05). There was no association between having a confidante and age, marital status or whether first or second generation.

Respondents who reported that they had a confidante were asked to state who it was that they confided in. Just over forty-one per cent (41.3%) reported that they confided in their spouses or partners. Almost one third (30.8%) reported that they could discuss their problems with more than one person, just over fourteen per cent (14.4%) reported that they talked to a female family member, one tenth (9.6%) stated that they depended on friends or colleagues, some three per cent (2.9%) shared their problems with a male member of the family and 1% gave various other answers. Single people (including divorcees and widowed) were more likely to talk to family members or colleagues. They were also more likely to confide in more than one person. Older or married /cohabiting respondents were more likely to confide in their spouse /partner (p=<.001).

Caring responsibilities

Participants were asked to indicate whether they or other members of the household were caring for anyone suffering from long standing physical illness, mental handicap or mental illness. They were further asked to state the age of the person whom they were caring. This was reported to be between 8 years old and 88 years old.

Table 8.15: **Respondents' caring responsibilities**

	YES %	NO %
Long standing physical illness	8.8	91.2
Mental handicap	0.8	99.2
Mental illness	4.6	95.4

Social activities

Participants were asked to indicate how often they have visitors or go out to for example, social clubs, eating out, religious meetings, or visiting friends and family. The vast majority, 71.8% reported that they socialised about once a week. Almost twenty

three per cent (22.5%) reported that they socialised at least once a month, and 5.6% reported that they took part in such social activities less than once a month or never. There was no association between frequency of socialising and age, gender, income, health or chronic illness.

Almost eighty per cent (79.6%) of the participants reported that they either never or very infrequently did any voluntary work. Nearly twelve per cent (11.7%) reported to have been involved in some form of voluntary work at least once a month, 6.6% stated that they did voluntary work once a week, only 2.2% reported to have been involved daily. Nearly 7% (n=2) reported to have been involved in fund raising whilst the others (93%, n=27) reported a number of various activities. Those aged 55+ were more likely to have been involved in voluntary work during the preceding year as were those who were not fully occupied and those who were married /cohabiting, however, these associations were not statistically significant (p=.18).

Respondents were asked to state whether they were generally satisfied with their social lives. Some 14.4% reported to be very satisfied, 65.1% to be satisfied and 20.5% reported to be dissatisfied. More men reported being very satisfied (23% versus 9%, p=.053). Dissatisfaction with social life was more common among those aged 35-54 (33% versus 12% of 18-34 year olds and 16% of those aged 55+, p=.052). Those who were single, widowed and divorced more frequently stated they were dissatisfied with their social life (27% versus 16%, p=.10). Dissatisfaction was also more common among first generation respondents (28% versus 12%, p=<.05), and among those on a low income (30% versus 13%, p=.08).

Respondents were also asked to say how happy they usually feel. The vast majority 65.5% reported to be happy, 6.2% stated to be very happy whilst 28.2% reported to be *'not very happy'* or to be *'very unhappy'*. The data were further explored to look at the associations with stress levels, health/chronic illness, and levels of happiness. More of those with high stress levels (6+) were dissatisfied with their social life (27% versus 12%, p=.07) as were those who in poor health or chronically ill (34% versus 16%,

p=.056). More than half (58%) of those who were not very happy/ very 'unhappy' felt dissatisfied compared with 8% of those who were 'happy' / very happy (p=.<.001).

Discussion of findings

The findings of this study indicate that Greek Cypriots enjoy fairly good social support systems and family networks. The existence of such networks are of immense importance and are closely associated with levels of stress and health. As this study has shown, those who were isolated were more likely to be dissatisfied with their social life and were more likely to be unhappy and to suffer higher stress levels. Naturally, this is a complex phenomenon for which would be difficult to isolate a cause and effect relationship. Helman (1990) reports that several authors have noted the importance of social support, at all stages of life, in protecting against stress which can give rise to physical and behavioural abnormalities (Weinman 1981, Brown and Harris 1979, Kiritz and Moos 1974). The Greek Cypriot community in North London remains a close knit community. Even though the cultural and social cohesion is constantly adapting and changing, it appears that even second and third generation Greek Cypriots retain their *'Greekness'* or *'Cypriotness'*. Furthermore, it is my belief, based on my membership and work with the community, that the second generation men and women continue to be very interested in our culture and are slowly becoming involved in activities which promote the interests of our community.

The levels of volunteering is somewhat disappointing but as I pointed out in the previous paragraph, this is gradually changing. However, it is worth pointing out that a definition of *'voluntary work'* was not given in the questionnaire and this may have led to inconsistent responses. The respondents may have perceived volunteering as something formal such as working for the Samaritans, Cancer Research, or other well known voluntary organisations. At a more informal level, taking a neighbour to the hospital, shopping for a house bound friend or neighbour, helping at one's child/children's school, may not be perceived as voluntary work but as an act of kindness or just being helpful. Traditionally, many first generation Greek Cypriots involved themselves (and still do) in associations which individuals from different Cypriot villages formed in order to

maintain social networks, friendships and their villages' memories and traditions. These self-help associations exist purely through voluntary membership and their maintenance requires a lot of voluntary activities; this type of activities may not be viewed as volunteering but as socialising activities. This lack of clarity may have influenced the findings. Volunteering, it seems, is not part of our culture. This is an area which is gradually being addressed.

RESPONDENTS' HEALTH AND THEIR USE OF HEALTH SERVICES

GP consultations

Respondents were asked to report the last time they consulted their family doctor (GP).

Table 8.16: **When was the last time you saw your GP?**

	%	(N)
Less than 1 week ago	14.8%	(22)
Less than 1 month ago	26.8%	(40)
Less than 3 months ago	24.8%	(37)
Less than 6 months ago	14.1%	(21)
Less than 1 year ago	14.1%	(21)
Less than 5 years ago	3.4%	(5)
Never	2.0%	(3)

Overall 98% of respondents had visited their GP in the last five years as compared to 96% of those in the NHLS 91 study. In my study 53% of the respondents had visited their GP within the last three months to a year as compared with 55% in the NHLS 91 study. Lastly, 41.6% of the respondents in my study visited their GP in the last week to a month as compared to a much lower figure of 30% reported in the NHLS 91.

Respondents were asked about the method of their last consultation with their GP. One hundred and forty three people (96.6%) reported that they last saw their GP in his/her surgery. One person (0.7%) reported to have spoken to the GP over the telephone and four persons (2.7%) stated that s/he was visited at home. The NHLS 91 study reported that 95% of the consultations took place at the GP surgery, 1% over the telephone and

4% at home.

Use of Accident and Emergency (A&E) departments

Participants were asked to report the number of times that they had visited the A&E department in the previous 12 months. Most of the respondents (79.7%) reported that they had not used the A&E department in the previous 12 months. Nineteen people (13.3%) had used it once, six people (4.2%) had used it twice, two people (1.4%) had used it three times, one person (0.7%) had used it five times and one person (0.7%) had used it nine times. Table 8.17 indicates the reasons for their attendance.

Table 8.17: **Reasons for attending the A&E department**

Following an accident	34% (n=9)
Referred by the GP	27% (n=7)
Unable to see my GP	23% (n=6)
Other	16% (n=5)

Men were more likely to have attended an A&E department in the previous year than women (27% versus 16%, p=0.10). Other correlates of attending A&E were explored: those with high stress levels (6+) were more likely to have attended (26% versus 10%, p=<.05) irrespective of whether they were suffering from chronic illness/ poor health. Those who were very satisfied with their social life, who also socialised more frequently, were more likely to have attended (40% versus 16% of those who were satisfied and 21% of those who were not satisfied, p=.056). Level of happiness was not associated nor was whether they were first or second generation.

Use of private medicine

Informants were asked whether they, or any member of their family use private doctors and why. Of the 132 people who answered this question forty six of them (34.8%) replied positively. Table 8.18 indicates the reasons for paying to see a doctor.

Table 8.18: **Reasons for using private medicine***

I wanted a second opinion	n=22
I could not see my doctor when I needed to	n=11
My doctor does not believe I am ill	n=5
My doctor would not prescribe the test I thought I needed	n=4
My doctor does not understand me	n=4
My doctor would not prescribe the medicine I need	n=3
Other reasons	n=15

* *(Numbers do not add to 46 as some respondents gave more than one reason)*

The data were explored to identify factors associated with the use of private medicine. Age, sex, and generation were not associated. Those with high stress levels more frequently reported using private medicine but this was not statistically significant (39% versus 27%, p=.17). The only income group who did not use private medicine in significant numbers were those who had a personal income of £2.5K to £4K (the second lowest income group): only 17% of this group used private medicine compared with 33% or more of the other income groups, however this was not quite statistically significant (p=.08).

Use of screening/ health "check ups" within primary care

Individuals were asked whether they are likely to use health promotion services if they were available at their GP surgery or the health centre, 82% replied positively. They were then asked whether they were invited by their family doctor to attend for a routine health check in the previous 12 months. 12.8% replied positively whilst a staggering 87.2% replied negatively. 90.5% of those who replied positively reported that they had attended for their check up. Of those who attended, 47.4% reported that the check up was performed by their own doctor, 42.1% were checked by a nurse and 10.5% by another doctor. The one person who did not attend stated that s/he had no health problem and therefore no reason to attend.

The NHLS 91 study reported that 79% of their informants would use a *'free health-check'* service in the next year if there was one available at their GP. Twenty seven per cent (27%) of the NHLS 91 respondents had been invited for a health check by their GP in the preceding year. Forty seven per cent (47%) of these health checks were performed by GPs and 53% by practice nurses.

Individuals were asked if they had ever had their blood pressure measured and if so when. Nearly ninety per cent (88.8%) reported that they had, which is similar to the NHLS 91 which found that 89% of their subjects had their blood pressure taken. Most of my subjects (53.7%) reported that their blood pressure was measured in the last six months, 17.9% reported it to be between seven and twelve months, 24.4% between one and three years, 1.6 % between three and five years and 2.4% reported that their blood pressure was measured more than five years ago. Just over 15% had been told by their doctor or the practice nurse that their blood pressure was higher than normal and 9.6% reported to be taking tablets for their hypertension. The HSE 91 reported that 86% of men and 95% of women had had their blood pressure measured by a doctor or a nurse at some time prior to their interview. 13% of men and 18% of women were told by the doctor or nurse that their blood pressure was higher than normal.

Respondents were asked whether they had ever had their blood cholesterol level measured and if so when. Nearly thirty per cent (27.6%) reported that they had. Most of them (41%) reported that the test was done between seven and twelve months previously, equal numbers (23.1%) reported to have had it done either six months or one to three years previously. Nearly thirteen per cent (12.8%) reported that they had the test three to five years previously. Just over twenty two per cent (22.5%) reported that they were told their blood cholesterol level was higher than normal. The Health Survey for England 1991 reported that 4% of men and 9% of women had severely elevated cholesterol levels (more than 7.8 mmol/l or more). The HSE 91 found that some 66% of their sample had raised blood cholesterol levels (above 5.2 mmol/l).

Individuals in my study were asked whether, during the preceding year, they had

received advice from any of the members of the primary health team on a range of health issues.

Table 8.19: **Types of health advice received during the previous twelve months**

	N	(%)
To take more exercise	26	(17.2)
Cut down or give up alcohol	5	(3.3)
Cut down or give up smoking	22	(14.6)
Change diet	28	(18.5)
Lose weight	27	(17.9)
Rest or relax more often	38	(25.2)
Get a better night's sleep	26	(17.2)
Use condoms when having sex	6	(4.0)

Percentages are of whole sample (n=151)

The most common type of health advice given was to rest or relax more and the least common was to cut down on alcohol consumption and to use condoms. The data were explored to see whether those who needed the advice were actually given it. It should be born in mind that getting advice is dependent upon having contact with health professionals; however only 8/149 (5.4%) had not seen their GP within the previous twelve months.

Activity and advice:

Of those who did not achieve their target (age and sex specific) levels of activity, 83.2% were not advised to exercise more. This result indicates that GPs or other primary health care staff who give health advice may not be aware of their clients' activity levels as there was no correlation between these two variables.

Weight and advice:

Of those who were categorised as overweight or obese 79.3% were not given advice about getting more exercise; the same proportion did not receive dietary advice, and 70.7% reported to have not been advised to lose weight.

Stress and advice:

Of those who reported high levels of stress (level 6-10), 68.8% did not receive advice to rest more and 75.6% were not advised to get a better night's sleep. As it has been found that exercise reduces stress levels, I explored the data to find out what proportion of people who had high stress levels were advised to exercise more: 80% of those with high stress levels were not given such advice.

Alcohol and advice:

Four respondents reported to have been given advice about their alcohol consumption although all four were currently drinking within safe limits. This may indicate that they had heeded the advice or that they under reported their alcohol consumption.

Smoking and advice:

Sixty per cent of occasional or regular smokers reported not having been given any advice about smoking.

Use of condoms and advice:

Ninety-two per cent of single/no longer married people were not given advice about using condoms compared with 99% of those who were married /cohabiting. Women were least likely to be given this advice as were those aged 35 and over.

Respondents were asked to indicate who was giving them health advice. Table 8.20 shows that on the whole, health advice is given by either the doctor or another health professional (respondents were not asked to specify). Nurses appear to be doing very little health promotion except in promoting the use of condoms.

Table 8.20: **Areas of advice given by members of the primary health care team**

	Doctor %	Nurse %	Other %
Take more exercise	42.3	19.2	38.5
Cut down or give up alcohol	40.0	None	60.0
Cut down or give up smoking	59.1	None	40.9
Change diet	42.9	3.6	53.5
Lose weight	51.9	7.6	40.7
Rest or relax more often	63.2	5.3	31.5
Get a better night's sleep	42.3	3.8	53.8
Use condoms when having sex	16.7	33.3	50.0

Health screening for women

Seventy five per cent (75%) of the women participants reported that the surgery they were registered with had a woman GP on the team. All the women participants (100%) reported that they could see a female doctor on the same day for an emergency, for a booked appointment, for family planning advice, for a cervical smear test and for other women's health problems.

Seventy six per cent (76%) of the women reported that they had been invited to have a cervical smear test, most of them reporting to have had their test either during the previous six months (30.4%) or between one and three years (30.4%). Nearly sixteen per cent (15.9%) had their test between the previous seven and twelve months, 13% between three and five years and 10.1% over five years previously. Fewer of those aged 65 and above were invited for the smear test (40% compared with between 56% and 94% of other age groups, $p=<.05$).

In relation to breast cancer screening, only 23.6% of the women reported to have had a mammogram or similar test. Some 5.6% were not sure whether they had been screened or not. Of those who responded positively equal numbers had had it done between one and three years (28.6%) and more than three but less than five years (28.6%). Nearly 10% had it done more than five years previously, whilst the rest ranged between less than six months and between seven and twelve months. All of those aged 55-64 had been invited for a mammogram compared with only 22% of those aged 65+ and 47%

of those aged 45-54, p= <.001.

The NHLS 91 reported that the overall smear test screening was 84% in the previous five years and in the case of mammography it was found that only 67% coverage occurred in the previous three years.

Discussion of findings

The use of health services provides an indicator of health status and demand for health care. This study has given some useful information about the use of GP services. However, I feel that I omitted this important question: *'How many times did you visit your GP in the last six months or a year'*. This would have added value to the question which was asked i.e *'When was the last time you saw your GP'*, the answer to which, were (retrospectively) not so useful. A person could have replied that s/he visited the GP in the last month but could have last seen the GP five years previously, and so on. One finding which deserves a mention is the Greek Cypriots have a lower than average home visit rate (2.7% versus 4% NHLS 91).

This section of the survey included questions on two areas which were not part of the NHLS 91. The two areas were *'use of A&E departments'* and *'use of private medicine'*. The first area was designed to test the commonly held assumption by many professional health carers that Greek Cypriots abuse the A & E departments either with minor complaints or instead of waiting to see their own GP. The survey revealed that only six (n=6) respondents used the A & E because they were unable to see their GP and a further five (n=5) gave their reason as *'other'*. This is a very low figure (n=11) and does not sustain the assumptions of those working or managing the A & E departments; this is a clear illustration of stereotyping, the possible effects of which were discussed in a previous chapter.

The second area was testing evidence which I had obtained from the Greek Cypriots whom I interviewed and some that I did not, but I had met socially; many had reported to me that for a variety of reasons they often paid to see a doctor. This assumption

appears to be more sustainable. A fair number (n=46 out of 132 of those who responded), have used a *'private doctor'*. The most frequent reason for this was that the respondents wanted to have a second opinion which must mean a lack of trust for their GPs. Two other reasons (*'my doctor does not believe I am ill'* and *'my doctor does not understand me'*) indicate the lack of communication between doctor and patient. This finding has been consistently highlighted in the literature over the last two decades and it is further discussed Chapter 10. Some of the reasons given for paying a *'private doctor'* could be the reaction to racist behaviour by the staff. McNaught (1987) reported that ethnic minority patients were kept waiting unnecessarily, that they received poor or no explanation of treatment or care, that staff assumed that minority patients were *'faking'* or were hypochondriacs, that treatments were delayed or inappropriate and that patients were denied medicine on the grounds that they had *'low pain thresholds'*. The recent survey on the health and lifestyles of black and minority ethnic groups in England by the Health Education Authority (1994) also supports these findings.

In respect of health *'check ups'*, it is encouraging to see that the uptake is high. However, there needs to be acknowledged, that particularly amongst the first generation Greek Cypriots, the attitude of *'I have no health problem and therefore no reason to go for tests'* still exists. Bouri (1992) also reported this attitude in her study about breast cancer amongst the Greek Cypriot women. The community itself, through its various organisations is beginning to have some impact in this area but much work still needs to be done.

Perhaps one of the most worrying finding of this study, is the level of advice given to those who need it by doctors and other health professionals. The area most neglected is that of physical exercise, the benefits of which are now fairly well established as already discussed. Advice about exercise would benefit everyone but in particular those who are overweight, are suffering from stress, or are at risk of developing heart disease. There is an urgent need for equipping primary health care staff with the necessary skills and resources so that they can integrate such advice in their clients' assessments and screening programmes (Papadopoulos and Worrall 1996).

Another observation is that nurses (practice and community) appear to be giving very little health advice. It may be that the respondents have less contact with the nurses as compared with that of the doctor. This area may need further investigation.

The Health Education Authority (HEA) Survey (1994) mentioned above, found that primary health care teams (PHCT)only have a limited impact in the provision of health information advice. It too has shown that the limited advice is mainly given by the GPs with other members of the PHCT such as the nurse, health visitor, dietician, midwife, counsellor and other, almost not featuring in its findings. Finally the HEA survey found, similarly to my study, that many critical health education areas such as use of condoms or issues around HIV/AIDS and sexual health were much less frequently discussed.

VIEWS ABOUT HEALTH AND CAUSES OF ILL HEALTH

Heart disease

Participants were asked a series of questions about the causes of and beliefs regarding heart disease. Firstly they were asked to select one of the following statements which was closest with their point of view.

Table 8.21: **Beliefs about heart attacks**

	Agree %
• Heart attacks can strike for no reason, they just happen. It's chance, fate, or plain bad luck	5.6
• There are reasons why people have heart attacks but we can do nothing about them, for instance, they are inherited, or happen for reasons we don't understand.	12.0
• There are some steps you can take that might help to cut down your chance of a heart attack.	42.4
• You can definitely reduce your chances of having a heart attack if you follow the right advice.	32.8
• Heart attacks could be avoided completely if only we lived our lives in the right way.	7.2

Eighteen per cent of respondents agreed with the first two statements which express a fatalistic view about the capacity to prevent heart attacks occurring. The majority (75%) had a more realistic view in believing that the individual has the potential for reducing their risk of heart attack, and 7% had an idealistic view.

Respondents were then presented with twenty factors and asked to rate their importance in relation to their contribution to the risk of having a heart attack.

Table 8.22: **Respondents' opinions about risk factors for heart attacks**

	Very Important	Important	Not at all Important
	%	%	%
High blood pressure	80.3	17.6	2.1
Fluoride in the water	2.6	19.7	77.8
Eating too much fatty food	82.2	15.8	2.1
Smoking cigarettes	75.5	19.6	4.9
Suffering from a sudden shock	39.1	53.6	7.2
Air pollution	18.3	42.0	39.7
Hard work	31.4	46.0	22.6
Not taking enough exercise	42.7	46.2	11.2
Stress/Stenochoria	71.8	26.1	2.1
Being overweight	72.0	25.2	2.8
Family history	56.1	38.8	5.0
Being diabetic	15.9	40.2	43.9
Unemployed	7.4	35.6	57.0
Not getting enough sleep	5.9	31.1	63.0
Using too much salt	24.3	48.5	27.2
Loneliness	8.8	28.7	62.5
Drinking coffee	2.3	37.9	59.8
Drinking too much alcohol	33.1	51.1	15.8
Not having enough money	7.5	36.8	55.6
Taking the oral contraceptive pill	1.5	26.2	72.3

In order to identify which respondents' were most knowledgeable about the contributory risk factors to heart disease a new variable was constructed: each of the responses to the 20 variables in the above table were assigned a score of 1 to 3. This score was then dichotomised at the median, a high score indicating more accurate knowledge. This variable was then cross tabulated with a number of independent variables (gender, age, education and income). Overall there were no statistically significant associations. Although there was no pattern in the degree of knowledge between age groups, those aged 65+ were more likely to have a low level of knowledge with only 10% getting a

high score compared with 54% of those aged 55-64, p=.10. Those with a higher education more frequently had high knowledge scores (59% versus 50% of the those who attended college and 35% of those who had a secondary education, p= .09).

Effects of behaviour on health

The participants in my study were asked to express their views about the possible effects of a number of behaviours on health. A series of questions were asked around diet, alcohol, smoking and stress. The results are presented in tables 8.23, 8.24, 8.25 and 8.26.

Table 8.23: **Diet as a related cause of illness and health problems**

	Yes %	No %
Lung Cancer	5.4	94.6
Arthritis	30.3	69.7
Heart disease	89.4	10.6
Diabetes	70.0	30.0
High blood pressure	84.6	15.4
Tonsillitis	0.8	99.2
Constipation	88.7	11.3
Obesity	95.8	4.2
Bowel cancer	53.5	46.5
Tooth decay	88.6	11.4
Gallbladder stones	46.5	53.5
Stomach cancer	50.4	49.6
Anaemia	61.8	38.2
Thalassaemia	4.8	95.2
Breast Cancer	8.6	91.4
Cataracts	9.2	90.8

Of most significance perhaps in Table 8.23 is the large proportions who were not aware of the link between diet and anaemia (38%) and diet and diabetes (30%).

Table 8.24: **Alcohol as a contributory factor to health problems**

	Yes %	No %
Anaemia	17.6	82.4
Car accidents	99.3	0.7
High blood pressure	86.4	13.6
AIDS	4.0	96.0
Lung cancer	14.0	86.0
Stomach ulcer	83.2	16.8
Chickenpox	0.0	100.0
Arthritis	9.5	90.5
Impotence	66.4	33.6
Liver cancer	97.9	2.1

The respondents seem to have a good knowledge about the health problems that are more likely to occur in people who drink alcohol. It was surprising to find that just over one third of respondents did not associate impotence with drinking, however this may be due to the over representation of women in the sample.

Table 8.25: **Smoking as a contributory factor to health problems**

	Yes %	No %
Heart attack	88.4	11.6
Bronchitis	93.2	6.8
Arthritis	16.4	83.6
High blood pressure	65.9	34.1
Stomach ulcer	55.1	44.9
Lung cancer	97.2	2.8
Diabetes	15.0	85.0
Stroke	62.8	37.2
Tonsillitis	29.5	70.5
Tooth decay	40.1	59.9

Around one third of respondents were not knowledgable about the association between smoking and high blood pressure and stroke, whereas a majority were aware of the association with heart attack. This may reflect the emphasis of health promotion programmes on the effects of smoking on the heart and lungs.

Table 8.26: **Stress as a contributory factor to health problems**

	Yes %	No %
Heart attack	97.3	2.7
Bronchitis	12.9	87.1
Arthritis	12.9	87.1
High blood pressure	97.3	2.7
Stomach ulcer	87.1	12.9
Diabetes	29.1	70.9
Asthma	54.1	45.9
Tonsillitis	11.3	88.7
Headaches	98.7	1.3
Diarrhoea	51.9	48.1

Knowledge about the effects of stress on health was generally good.

Knowledge and health behaviour

In order to explore the relationship between knowledge (about diet, alcohol, smoking and stress), its effects on the diseases in the tables above and actual health behaviours, knowledge scores were constructed. The number of correct responses for each of the items in the lists above were counted. These scores were then categorised as *'low'* or *'high'* by dichotomising around the median value. These knowledge variables were then cross tabulated by a number of relevant independent variables.

The findings revealed that eating and knowledge about diet were not correlated: almost equal proportions (around 50%) of those with a high knowledge score ate a poor diet as those who had a low knowledge score. Equal proportions of those with a high score on knowledge about the harmful effects of smoking were regular smokers as those with a low score. A similar absence of association was also found between knowledge about the benefits of exercise and exercise participation, as already discussed. These findings indicate that knowledge alone does not lead people to live healthier lifestyles.

Sexual health

Respondents were asked to report whether they had used condoms in the last year. Of the 111 who answered, over a quarter (27%) said they had, 11% said they regularly carry condoms to protect themselves from sexually transmitted diseases. They were then asked whether they would avoid using condoms for the reasons listed in table 8.27.

Table 8.27: **Sexual health: Reasons for avoiding to use condoms**

	Yes	No	Not Sure
	%	%	%
Obtaining condoms is too embarrassing	9.2	82.7	8.2
Condoms are too expensive	6.3	76.0	17.7
There aren't enough machines when you need to buy some	6.3	64.6	29.2
I can't get condoms from my GP on prescription	3.2	64.9	31.9
Condoms reduce sensitivity	34.4	51.6	14.0
My partner would not like using condoms	21.7	63.0	15.2
You look cheap if you carry condoms	9.6	78.7	11.7

The main reason given for not using condoms was that they reduce sensitivity and secondly that they felt their partner would not like using them.

Discussion of findings

The findings in this section of my survey indicate that the Greek Cypriots have a fairly good knowledge of the factors which cause heart disease and of the effects of their behaviour on their health. However, there is an inconsistency between knowledge and behaviour. Respondents continue to follow unhealthy practices even when they indicated that they were aware of these. As mentioned earlier, knowledge alone does not lead to healthier lifestyles. Some of the responses to the statements about the respondents' beliefs about the onset of heart attacks, indicates that individuals function within a *fatalistic-realistic-idealist* health belief model which is sustained by a strong dose of denial. It is probably the denial which influences people's motivation and action. Bouri (1992) found that many of her informants explicitly denied the existence of illness in themselves and their families. This is not surprising if we consider that health is considered as a prerequisite for one's ability to function properly as a member of the society, meaning being productive. Being able to work hard and earn as much as one could was the philosophy which the first generation of migrants adopted, most of whom left Cyprus for a better economic future as discussed in chapter 1. This philosophy is still very evident today. Often the type of work and pressure of work (working in restaurants, owning a shop or a small factory, doing piece-work etc) may be the cause for self neglect or adopting risky health behaviours. All these point towards the need for focusing on health promotion strategies which will aim at motivating the Greek Cypriots to look after their health.

FINDING OUT ABOUT HEALTH ISSUES

Topics for which respondents would like to know more about

Table 8.28 lists the participants' responses to a number of topics about which they wished to have more information.

Table 8.28: **Topics about which the respondents would like more information**

	Yes %	No %
Plans of local hospitals and community services for following year	72.4	27.6
Reduce risk of having a heart attack	72.1	27.9
Reducing stress in their life	70.3	29.7
Eating a healthier diet	68.1	31.9
Health Authority's plans for following year	64.9	34.2
Getting a better night's sleep	46.6	53.4
Losing weight	45.0	55.0
Reduce risk of getting HIV/AIDS	24.0	76.0
Giving up smoking	17.6	82.4
Cutting down on alcohol	9.9	90.1

Discussion of findings

During the last five to ten years enormous changes have happened to the national health service system. For those working within the system, the majority of these changes seem inevitable and desirable. Demographic, epidemiological, technological, economic and political forces are driving these changes. The Health of the Nation Strategy (DoH 1992) emphasised the importance of informing local people of any proposed changes and of involving them in planning and decision making. During the field work which proceeded this survey and which was done during 1992-1994, I discovered that Greek Cypriot people were very ignorant about the changes which were taking place or the general direction towards a primary care led NHS. They had heard of or witnessed hospital closures and they were very critical about this change. The majority saw the hospital as the focus of health care and their judgements about the NHS were totally hospital based; those who have had *'positive hospital experiences'* tended to think that the NHS was marvellous whilst those who had encountered *'negative hospital experiences'* thought that the NHS is going from bad to worse. It is interesting to note that by 1995 people are putting their wish to learn more about the health authority's plans on top of their list. This in my view indicates the failure of the Health Authority to inform and involve the local population in an effective way. This failure shows very clearly how difficult it is to change traditional ways of operating and perhaps most importantly, of changing the ideology of *'the professionals know best'* to one which requires a balance in this power relationship.

Reducing the risk of having a heart attack, eating a healthier diet and reducing stress, are all connected and reflect many of the previous findings in my study. Greek Cypriots are well aware of levels of heart disease within our community and its associated causes. The community fears heart disease because it affects young and old and because it can have sudden and devastating effects. However, during the last ten years the government has funded a number of initiatives which aimed at informing the public about these issues. In view of this topic featuring so prominently in the priorities of the Greek Cypriot community, as well as the evidence which this survey has provided, we need to question whether the message is getting through. The effectiveness of health education programmes in general, is continuously being debated at national level. At a more local level, there must be more investment in finding the most effective and culturally sensitive methods of delivering such programmes to meet the needs of local communities. It is often assumed by health planners and providers that the only problem faced by the Greek Cypriot community is that of language related to individuals from the first generation. This is clearly wrong.

OTHER VIEWS

Of the 151 participants, 63 offered a range of views about how we could all work towards making the Greek Cypriot community in Enfield and Haringey healthier. Their views fall in to the following categories:

The need for information
The need for education
The need for services
The need for Greek speaking staff
Other suggestions

The need for information

Respondents suggested the need for information at two levels: for adults and for children/teenagers. Most of them have indicated that the Greek community needs to

be provided with information on healthy eating and exercise. Respondents were concerned that children/teenagers, were provided with information regarding sexual health, the risks of HIV/AIDS as well as diet and exercise. It has been proposed that this information is provided in the form of leaflets, booklets which are both available at clinics and community centres but were also regularly mailed to Greek people. The need for reinforcing this information at regular intervals was highlighted through the suggestion of the production of a newsletter on health topics. Many emphasised the use of Greek radio and newspapers as very appropriate media for the dissemination of such information.

The need for education

This is related to the need for information. Respondents suggested that the Greek community needs to be educated on the topics mentioned above through meetings with guest speakers who will provide the *'real facts'* about these topics thus raising peoples' awareness and knowledge. It was recommended that cookery demonstrations could be used which would enable individuals to cook healthier food whilst maintaining the Greek traditions. Another topic which was highlighted for action was the need for *'stop smoking'* programmes. Greek schools were seen as having an important role to play in educating children and young people towards healthier lifestyles. The need for a co-ordinated approach between Greek schools, Greek radio and Greek newspapers and Greek community organisations was also identified. This is an important indicator of the wish of the Greek community to initiate action and take control of their health.

The need for services

This was mainly around two areas: the need for nursing/old peoples homes with Greek speaking carers and the need for a Greek community centre. Many of the respondents appeared concerned about the growing number of elderly needing care, some of whom would eventually be unable to continue living at home. In view of their language difficulties (and it appears that of many others) it was repeatedly recommended that there is an urgent need for more Greek speaking staff and interpreters. The need for a Greek community centre was probably highlighted by those living in the London

Borough of Enfield where such a centre does not exist, whereas these are provided in the London Borough of Haringey. Respondents viewed such centres as the focus for accessible and appropriate information, education and health promotion services including health check-ups and screening. Such centres were also viewed as meeting places for socialising, exchanging ideas and sharing problems as well as for recreational events encompassing keep-fit classes.

Other services which were featured are, more female doctors who would deal with gender related health problems, as according to one respondent ***"a lot of women would rather not have the examination done (cervical smear) if they can't be examined by a female doctor. For some this can be fatal"***, or as another respondent expressed it ***"trying to encourage women about the importance of having the various tests, like cervical smears, breast screening etc, which many still find embarrassing to come forward to have".***

The need for Greek speaking staff

Many respondents expressed concern about the dearth of Greek speaking health professionals such as doctors, nurses and carers. The rationale for this as discussed above, was the number of first generation people who have language difficulties. More important than language is perhaps the ability to provide culturally sensitive and competent care; the respondents seem to imply that by having more members of the Greek community entering these professions they would not only provide such care themselves, but they would also help others to understand the Greek culture and apply this knowledge when caring for Greek people.

In addition to the above the need for more Greek interpreters was identified, especially for hospitals and GP surgeries.

Other suggestions

Is was suggested that the Greek community needs to be encouraged through various means to become more open about mental illness. As one respondent expressed ***"the***

mentally ill need a lot more support and the community should stop seeing them as a shame to society". Such comments imply that mental illness is still regarded as a stigma within the Greek community.

There was a plea that doctors should give more time to people in order to discuss their problems more fully. The issue of waiting times, both for GPs or a hospital appointment was also raised.

Finally, a minority of respondents took a more passive and /or fatalistic view regarding the health of the Greek community typically expressed by one respondent as ***"leave it to the experts"*** and another ***"the Greeks are pretty thick when it comes to these matters. I do not think that they will listen".***

Discussion of findings

The findings of this section confirm some of the findings in the previous sections but also serve to highlight the major concerns of the respondents. These findings strongly suggest the need for more information and education; most importantly they raise the issue of accessibility and appropriateness of such information and education. However, the sheer focus on these needs also highlights the lack of awareness on behalf of the respondents, of the available information and health education. These negative findings need to be taken on board by those who plan and provide these services to ensure that messages are reaching those for whom they are intended and that resources are not unnecessarily waisted. One way of achieving this would be to increase the involvement of the Greek community and to adopt a collaborative model of service development and delivery, including the relevant local authority departments.

The concerns about diet and exercise were very appropriately identified as the most important health issues and this view is supported by the findings of this survey as discussed in earlier sections.

In relation to the need for services the evidence points towards the development of a self

help culture within the Greek community. All the indicators signify that Greek people wish to be involved in their own health care and that of their community in general. They are concerned about the *'now'* (their wish to have community centres) but are also planning for the future (provision of homes and services for the elderly). These concerns are in contrast to those which were expressed by some respondents who suggested that these issues are best left to the experts. We now see another aspect of the *'fatalistic-realistic-idealistic'* model which began emerging in the section about health and illness views, this being the *'active-passive'* dimension.

A lot was said about the need for Greek speaking health professionals. This issue deserves some comment for two interconnected reasons. The first one is that of Greek representation in health care professions. Anthias (1992) reported that Cypriots are under-represented in the professional occupations and over-represented in the self-employed and small employer category and in semi-skilled and unskilled work. This, she argues, is the result of the migration processes associated with Greek Cypriots for example, the type of migrant, the reasons of migration, the cultural value system of migrants, as well as the difficulties and discrimination which they faced in this country. Their experiences had and still do influence them and their families, resulting in many of their children underachieving at school, or being encouraged to work in family businesses. The situation is gradually changing and we are seeing a few second generation individuals taking up a career in medicine. This, however seems to be the exception. The Greek community, like many other communities, has always viewed medicine as one of the most noble professions. The same cannot be said about nursing or midwifery. Most Greek people greatly appreciate the care they receive from nurses and midwives but would not like their daughters and least of all their sons to enter these professions. The evidence which I gathered during the group and individual interviews which I conducted in 1993 and during another small study on this topic which I conducted with a colleague in 1995-96, suggests that Greek Cypriots continue to hold the traditional negative views about these professions (Papadopoulos and Tilki 1996).

This position illustrates another contradiction; the Greek Cypriots are recognising the

need and value of having members of their community working as health care professionals but despite this, they continue to discourage their children from entering the biggest caring professions.

Another area where attitudinal change is not occurring (or if it does is extremely slow), is that of mental illness. This remains to be a stigma within the community and many families would not only admit to having one of their members suffering from it, they would try to conceal it. As discussed in an earlier section, many individuals are reporting high levels of stress; the womens' study (Papadopoulos and Worrall 1996) revealed that many of them suffer from mental health problem and some are on medication. But whilst *'suffering with my nerves'* (the term usually used to express stress or depression) is very often openly shared with others who demonstrate sympathy and understanding for a person with this predicament, having a family member suffering from schizophrenia or any other mental illness which requires hospitalisation or renders the individual less capable of having a *'normal life'*, would be associated with madness. It is no wonder that families often try to conceal it, often try to deal with the person without seeking help. Mental illness is an area which clearly needs to be opened up, discussed and dealt with.

Finally, the issue of long waiting times was again highlighted in the respondents' comments. Long waiting times for hospital treatments has been one of the government's target area for improvement and some reductions are periodically reported in the annual *'league tables'* published by the government (statistics on the performance of health services). This undoubtedly needs to be taken into consideration when discussing the Greek Cypriots' reports for waiting too long for a hospital appointment or (much more frequently reported) for a GP appointment. As discussed in a previous section, there is evidence to support the view that people from minority ethnic groups do not simply have a natural aversion to waiting, or that they expect to be seen on demand, but they are experiencing indirect discrimination from racist staff and policies. This results in having to wait longer. But if certain community groups find -particularly when it comes to seeing the GP- it difficult to accept the appointment system, to insist in adhering to it

when it may be failing, often large numbers of particular groups, would be unreasonable. The system, like any other system needs to be under constant review and adjusted to suit the differing client groups.

SUMMARY

In this chapter, the findings of the health and lifestyles survey which involved a random sample of Greek Cypriots living in the London Boroughs of Enfield and Haringey, were presented and analysed. Further interpretation of these findings is offered in Chapter 10 which brings together findings from the exploratory qualitative study on the health and illness beliefs, lifestyles and behaviours of Greek Cypriots (reported in Chapter 7), as well as findings from the survey of the views of health service purchasers and providers in Enfield and Haringey, which are reported in the following chapter (Chapter 9).

CHAPTER 9

THE VIEWS OF THE HEALTH SERVICES PURCHASERS AND PROVIDERS

INTRODUCTION

Health service providers and purchasers were surveyed in order to identify the extent of their awareness and understanding of the health needs of the Greek Cypriot community and to find out how they, and the organisations within which they worked, were trying to meet the needs of this community group.

The survey was conducted in two stages. The first stage took place in 1994, when five (n=5) individual interviews took place. The second stage took place in early 1995 and involved the administration of a postal questionnaire to the chief executives of two acute and two community Trusts in Enfield and Haringey, the chief executive designate of the Enfield and Haringey Health Authority and the Chair of the GP Commissioning Executive.

Table 9.1: **Interviews with purchasers and providers**

ROLE	PURCHASER/ PROVIDER	GENDER
Director of Needs Assessments	Purchaser	Male
Commissioner for Health and Race	Purchaser	Female
Health Visitor	Provider	Female
Team Leader Health Visiting	Provider	Female
Community Locality Manager	Provider	Female

INTERVIEWS WITH PURCHASERS AND PROVIDERS: FINDINGS AND DISCUSSION

Theme 1: Needs assessment

Theme elements: The purchasers' views
The providers' views

Theme 2: Assessment of the needs of the Greek Cypriot community

Theme elements: The purchasers' views
The providers' views

According to the purchasers, a *'project'* approach to needs assessment was adopted in Enfield and Haringey. Projects were set up depending on the priorities identified by the Health Authority (HA) and the available resources. Nationally available information was used whilst local information was collected using various methods, depending on the style of the project leader. It was then up to the project leader to convince the HA Directors that the need which they had identified deserved funding. Both purchasers appeared to be informed about the needs to examine the health of the minority ethnic groups in a focused way and were keen to see more developments which addressed these issues. The examples which were offered were: the *'refugee project'* which involved a number of projects about the health needs of the refugee communities. The other example, was the establishment of a *'Health and Race'* committee, and they both hoped that it should have enough power and authority for action and that it would not end up as another talking shop. In addition both wished to see a better linkage between needs assessment and the decision making processes within the HA.

The providers' views were that they did not contribute to the needs assessment projects which the HA was conducting even though both health visitors and district nurses were trained to assess the needs of their local population. In their view the HA should have a system, through which information from those closest to the clients, is collected, analysed and used. They thought that the needs assessment system was a

'hotchpotch'. They all thought that culture effects peoples' lifestyles and that it should be taken into consideration when making purchasing and providing decisions.

With regards to the needs of the Greek Cypriots, the purchasers reported that the Health Promotion Directorate had carried out investigations which included the Greek Cypriot community. They reported that the HA contracts did not specify standards or specific functions for each ethnic minority in the area but they had a general statement that the service must be appropriate to individuals' cultures. But ***"...we have not reached the stage when we can say with certainty that health care is culturally sensitive to all our people; we are trying".***

The providers on the other hand, reported that they were not aware of any needs which were specific to the Greek Cypriot community. They reported that some elderly have problems with the language but ***"...they usually have a member of the extended family available".*** They also implied, through talking about people from minority groups, that sometimes there is a problem with compliance with the professional's advice and that this was due to lack of understanding; people usually conformed after they had received information and explanation in a form which they could understand.

POSTAL QUESTIONNAIRES

As mentioned above, in 1995, the chief executives of two acute and two community Trusts in Enfield and Haringey were sent a questionnaire to elicit their views on a number of issues related to the provision of health services for the Greek Cypriot community. All responded, with the exception of the acute Trust in Enfield despite several reminders.

The purchasers' views were also sought as previously stated. The scenario in this case is slightly more complicated. As discussed in Chapter 3, the purchasing and commissioning of health services in Enfield and Haringey were until April 1995 divided between the New River Health Authority which dealt mainly with the acute

hospital services, and the Enfield and Haringey Family Health Services Authority which dealt with the community and primary health services. In addition, the new General Practitioner (GP) funding system also gives the fundholder GPs a purchasing role. At the time of seeking the purchasers views, the two health authorities had come together as a shadow health agency in preparation for the forthcoming NHS changes which required the merging of the two types of health authorities into one, which would deal with both acute and non-acute sectors with an emphasis on primary health care. The questionnaire was sent to the Chief Executive designate of the new authority. Another questionnaire was sent to the Chair of the GP Commissioning Executive but this was returned uncompleted with a letter from the group's administrator stating that the group "*...aims to represent the views of GPs with regard to the commissioning of health and social care for the residents of Enfield and Haringey to the statutory authorities and as such it is not a purchaser or provider of services. Given this, it was considered that completing the questionnaire would not be relevant*". It could, however be argued, that even though some of the questions might not have been relevant, given the expressed aim of the group and the purposes of the study as expressed in the letter which accompanied the questionnaire, the Chairman or a senior member of the group could have responded by stating how they represent the views of the Greek Cypriot community and on what basis. It could also be argued, that the absence of any written statement about their commitment to the health of this community group, coupled with the lack of any epidemiological, demographic or ethnographic data, is resulting in the failure of this important commissioning executive, to represent the interests of the Greek Cypriots living in Enfield and Haringey.

FINDINGS: THE PROVIDERS

Two of the Trusts which responded, had their questionnaire completed by a senior member of the Trust (the Director of Administration and Operations/Chief Nurse, and a Locality Manager). The third Trust, distributed copies of the questionnaire to heads of services which resulted in eight (n=8) responses as follows: The Clinical Director, Department of Medicine for the Elderly, the Director of Child and Adult

Community Services, the Manager of Speech and Language Therapy Services, the Head of Foot Health, the Head of Occupational Therapy, the Director of Human Resources, the Director of Estate Facilities, and the Director of Mental Health. However, two of the responses had only the first and third page of the questionnaire returned. Three of them were in the form of summary letters. Interestingly, the Director of Nursing and Quality who co-ordinated everyone's responses did not complete a questionnaire for those services.

A. The providers were asked to state whether or not they have a mission statement which is communicated to all their staff and service users, and if they did, they were requested to either give details or to attach a copy to their completed questionnaire.

Two of the three Trusts responded positively. The two mission statements read as follows:

Provider 1: *"To provide quality and value for money in the provision of health care to the people who use our services"*

Provider 2: *"We exist to serve our population and are committed to providing high quality, accessible and cost effective services. We believe our local population -especially the elderly and the disadvantaged- needs a broad range of services, but our strategy is also to specialise in certain key areas. By creating centres of excellence that will differentiate us from other hospitals we will attract income from other health districts as well as delivering the highest quality service to our local people".*

B. The providers were asked to express their views about the commitment of their organisation to provide services which are culturally sensitive to the Greek Cypriot community and to offer examples of how this commitment is put into practice. If they do not provide such services, they were asked to state why.

Provider 1, responded that they were indeed committed to this and offered as example a proposal to develop services for sickle cell and thalassaemia by funding a clinical nurse specialist/counsellor working in conjunction with the acute /trust in the borough and the *'George Marsh'* centre (specialist centre for haemoglobinopathies, in Haringey).

Provider 2, also responded positively but failed to give any examples.

Provider 3, gave a number of examples. The **Clinical Director for Medicine for the Elderly** stated that they have easy access to Greek translation services, they allow and encourage cultural foods to be brought in where appropriate and fitting with the medical condition, and that they have easy access to Greek Orthodox Priests who are allowed open access to patients as required. **The Manager for the Speech and Language Therapy** services, stated that the department is committed to providing culturally sensitive services to all their ethnic populations including the Greek and Greek Cypriot communities. The translation service for clients and carers is cited as well as the availability of leaflets translated in Greek. They also employ one therapist who speaks some Greek. In addition, treatment programmes are developed in consultation with the client and carers, and in the case of children this involves their parents and teachers. The **Director of Facilities** reported that there are plans to produce the menu cards in all predominant languages although meals are provided to suit all relevant ethnic groups. The **Head of the Occupational Therapy** service replied that they use the linkworkers, and that they have plans to translate some leaflets into Greek. It was also stated that all patients have individualised assessments and their personal preferences and culture are taken into account, though not stating how this is achieved. The **Directors of Human Resources and Child and Adult Community Health Services** did not respond to this question whilst **the Head of Mental Health Services** reported that they do not have any specific services in mental health dedicated to the Greek Cypriot community, but did not state why. The **Head of Foot Health** also reported negatively but added that this is due to the fact that he did not know what he needs to provide so that his service can be culturally sensitive to the needs of this community group.

C. **Providers were asked to state whether, in their view, their organisation is committed to providing services which are easily accessible to individuals from the Greek Cypriot community, to give examples of how this is achieved, and if it is not, to state why.**

Provider 1 responded that they do provide such services and gave as an example the use of linkworkers.

Provider 2 also reported positively. As an example, the respondent enclosed a signate chart which lists all the Trusts services and departments (which are colour coded) in Greek.

Provider 3 gave the following responses:

The **Clinical Director, Department of Medicine for the Elderly**, stated that

> *"with regard to accessibility, as most of our services are acute emergencies, there is no differentiation between any ethnic group. This is also true for other parts of our service, such as out-patient, Day Hospital, domiciliary visiting etc".*

The **Manager of Speech and Language Therapy Services**, reported that clinics are held in areas where many residents are from the Greek community. A copy of their own patient charter in Greek was attached.

The **Director of Human Resources** reported to be unable to respond, this (and the following two questions) being *'patient orientated'* rather than *'staff orientated'* questions.

The **Director of Estate Facilities**, stated that the main sign boards have explanatory notes written in Greek and seven other languages.

The **Director of Mental Health** stated that this is provided in the same way as it is for the other residents in the borough.

The **Director of Child and Adult Community Services**, did not respond to this question or the following three questions.

Unfortunately the page containing this question and the following three questions, were missing from the returned questionnaires by the **Head of Foot Health and the Head of Occupational Therapy.**

D. Providers were asked to state their opinion as to whether they were providing adequate services to deal with the different needs of the Greek Cypriot community.

Provider 1 responded that they were not providing adequate services and qualified this by stating that

"specific needs have not been identified either through purchasers or focus groups".

Provider 2 reported that they were providing adequate services but stated that

"this is dictated by contracts with purchasers, and that the quality specification includes a health ethnicity component".

Provider 3 responded as follows:

The **Clinical Director, Department of Medicine for the Elderly,** stated that there are adequate services to deal with the different needs of the Greek/Cypriot community.

The **Director of Mental Health** was of the opinion that they did not provide adequate services but they did in the past employ a community mental health nurse who was of Greek/Cypriot origin.

The **Manager of Speech and Language Therapy Services** reported to be happy with the services they provide.

E. Providers were asked whether in their view they provide services which promote the health of the Greek Cypriot community, to give examples or in the case of a negative response to explain why .

Provider 1 stated that they did not provide such services repeating the reasons as those given to the previous answer.

Provider 2 reported that they did provide such services stating as examples

"This is largely a purchaser responsibility and is thus included in contract specifications".

Provider 3 answered as follows:

The Clinical Director, Department of Medicine for the Elderly, stated that

> *"We do have some health promotion material translated into Greek, which is given out to patients".*

The Director of Mental Health reported that they did not provide services which are promoting the health of this community group but failed to give reasons why.

F. Providers were asked to say whether they involve Greek Cypriot people in the decision making processes of their organisations, to specify who is involved or if they did not involve anyone from this community group, to state the reasons why.

Provider 1 reported that they are involving the community in their development of a haemoglobinopathy strategy.

Provider 2 stated that they did not involve people from this community group but added,

> *"In a minor way only through the views of our patient representative forum which includes Greek Cypriot members".*

Provider 3: **The Clinical Director, Department of Medicine for the Elderly**, stated

> *"We do not specifically involve Greek and Greek Cypriot community representation, although the CHCs for Enfield and Haringey do raise issues about ethnic minorities including Greek Cypriots".*

The Director of Mental Health reported that they involved members of staff who are of Greek Cypriot origin, (although as reported previously, the one member had in fact left the organisation).

The Director of Human Resources reported that one member of staff was Greek Cypriot but his/her involvement would be similar to that of other staff.

G. Providers were asked to say whether their organisation has a health status profile for its Greek Cypriot community, and if it does, to describe the information which is included, whereas if it does not, to state why.

Provider 1 reported that the organisation did not have such profile but declined to state why.

Provider 2 also reported that they did not have such profile but stated that they were developing one with the purchasers.

Provider 3: The Clinical Director, Department of Medicine for the Elderly, stated that the answer was no and thought that this question should be answered by the purchasers.

The Director of Child and Adult Community Services, replied that such profile exists to an extent, stating that information on vulnerability to particular conditions such as thalassaemia and substance misuse, although not comprehensive, is available.

The **Heads of Foot Health and Occupational Therapy** reported negatively but failed to give reasons why.

None of the other respondents answered this question.

H. Providers were asked to state whether the information on the services they provide is available in Greek, to give examples or state why, if it is not.

Provider 1 reported that this information is not available in Greek but is available in Asian languages and in Turkish.

Provider 2 reported that the information was available in Greek and gave as an example the signate chart which was referred to in a previous response. A copy of their patient charter was also enclosed, which although it was in English, did have a message in Greek asking those who needed help with it to contact the linkworkers.

Provider 3 respondents stated that some information is available in Greek, but they will endeavour to have more material in Greek in the future.

I. Providers were asked to state whether they provide health promotion material in Greek.

The view of **Provider 1** was that they did not.

Provider 2 reported that they did, but suggested that the Health Authority's health promotion department would be able to provide examples.

Provider 3: Three of the respondents reported that they provide some health promotion material in Greek. Three, did not respond and the relevant page from two of them had not been returned.

J. Providers were asked to say whether or not their organisation was providing an interpreting/advocacy/link work service, and if they did to specify the extent of this service.

All those who responded reported that they were providing this service.

Provider 1 stated they purchased the service on sessional basis as and when it was needed.

Provider 2 stated that the service was provided Monday to Friday, 9am to 5pm and that an *'on call'* out of service hours provision was being developed.

Provider 3: The **Clinical Director, Department of Medicine for the Elderly,** stated that one of the sites (services for the elderly is divided in two sites) has an excellent interpreting, advocacy and linkworker service and due to the fact that the linkworker service is also located there the availability is very good. At the other site the availability depends on a booking arrangement.

The **Director of Child and Adult Community Services,** stated that the linkworker scheme provides a service for all health providers in the borough. This person (who incidentally manages the linkworker service) is of the view that if the service was fully utilised it would not be able to meet the demand.

K. Providers were asked to explain how their organisation ensures that its services are responsive, appropriate and acceptable to the Greek Cypriot clients. These being indicators of quality, the respondents were asked to state how their organisation was monitoring these indicators, and if it was not, to state why.

Provider 1 reported that these quality indicators were not being monitored and stated that s/he was unable to answer why.

Provider 2 reported that the above quality indicators were monitored through liaison with the Community Health Councils, and their own patients' representative forum.

Provider 3: The Director of the Department of Medicine for the Elderly reported that,

> *"We have no specific questionnaire aimed at the Greek Cypriot community. We use our usual patient satisfaction surveys to audit satisfaction on the wards, which often include some Greek Cypriot patients".*

There were no other comments about this question from any of the other participants.

L. Providers were asked to state their view regarding their organisations' provision of services for the growing number of Greek Cypriot elderly.

Provider 1 reported that in her/his view the organisation did not provide adequate services for this group of people.

Provider 2 reported that,

> *" this could obviously be improved but we need the input from the Greek Cypriot community groups".*

Provider 3: The Director of the Department of Medicine for the Elderly reported that,

> *" we feel ...that we are providing an adequate service to deal with the Greek Cypriot elderly, as their needs are mostly translation, advocacy, cultural sensitivity around food, attention to special medical diseases such as thalassaemia, and availability of religious personnel as necessary".*

The Director of Child and Adult Community Services, stated that,

> *" We do not have services specifically for elderly Greek Cypriots. We do have services for ethnic elderly and as noted previously there is the Linkworker service".*

The **Director of Mental Health** reported that they do not have specific services for the Greek Cypriot elderly.

There were no other responses.

M. Providers were asked to express their views about their organisations' provision of services which deal with specific needs of the Greek Cypriot women.

Provider 1 reported that there are no specific services apart from the care given when attending child health clinics.

Provider 2 stated that,

> *"input from Greek Cypriot womens' groups could help to improve services further".*

Provider 3 responses ranged from *'no'* to *'no response'* to,

> *"I am not clear what the special needs of Greek Cypriot women are, besides the above* (referring to translation, food, thalassaemia and priests). *Clearly if a female patient particularly wants to be examined by a female doctor, we would do our best to provide this, although it is not always possible if we do not have a female doctor working in our service".*

N. Providers were asked to state whether their organisations provided training for its staff to enable them to deliver culturally and linguistically sensitive care to their clients.

Provider 1 stated that this was not being provided due to cost implications.

Provider 2 also stated that this is not provided but that it is being developed.

Provider 3: The **Director of Child and Adult Community Services**, stated that the training department of the Trust runs a suitable course . The **Manager of Speech and Language Therapy Services** reported that most therapists subscribe to the College of Speech and Language Therapists special interest group in bi-lingualism

and attend training events around the issues of ethnic minority groups. **The Director of Human Resources** (responsible for staff training), reported that there is a multi-cultural -but not linguistic- content to their basic training programmes. No further detail was given. There were no other comments from the other participants.

O. Finally, the Providers were asked to offer any comments which may be of help to this research study.

Provider 1 and 2 did not respond.

Comments from **Provider 3** were:

> *"...we are looking to encourage our new business manager to make links with various ethnic minority representative groups, which would include the Greek Cypriot community".*

And,

> *"It would be helpful to have more information on the specific needs of this client group and any element of good practice found elsewhere".*

FINDINGS: THE PURCHASER

As reported at the beginning of this chapter, the purchaser/commissioner questionnaire was sent to the chief executive designate of Enfield and Haringey Health Agency (now known as E&H Health Authority). The questionnaire was however, completed by one of the HA's contract managers.

The questionnaire was almost identical to that sent to the service providers with only minor changes to the wording of the questions to reflect the responsibilities of the purchasers/commissioners.

The mission statement which was supplied was that of the New River Health Authority (NRHA). Obviously, as the health authority and the family health services authority were only at the beginning of the process of merging into one authority, a

common mission statement had not been developed. The NRHA mission read as follows:

- *To promote health and healthy living within the New River Health Authority.*
- *To influence and work in partnership with key local agencies as a catalyst to achieve health gain.*
- *To purchase hospital and community services to meet the needs of the population of Enfield and Haringey.*
- *To improve the two-way communication with local population.*
- *To develop our organisation and its personnel to be recognised as a leading commissioning health authority.*

The respondent reported that the Health Authority is committed to commissioning health programmes which are **culturally sensitive** to the Greek Cypriot community and gave the following examples:

a) *The Authority funds the Enfield Refugee consortium and two schemes which provide day care for the frail confused and disabled elderly at the Greek and Turkish Cypriot Centres.*

b) *The Authority also employs a worker to assist in building of the ethnic minority voluntary sector groups.*

It was reported that the Health Authority is committed to the provision of **easily accessible services** for members of the Greek Cypriot community. Examples given were the Linkworker Scheme and the translation of literature.

The respondent reported that the Health Authority is committed to providing adequate **services to deal with the needs of the Greek Cypriot community.** Examples offered as per question number 3 above.

It was also reported that the Health Authority is committed to promoting the health of the Greek Cypriot community *'through health promotion programmes'*. No specific examples given.

According to the respondent the Health Authority is **involving the Greek Cypriot community in the needs assessment process,** but no examples to describe how this was achieved, were given. Purchasers were also asked to name the individuals or the organisations involved in this process. This information was not offered.

The respondent failed to answer the question **"Does your organisation have a health status profile for its Greek Cypriot community".**

In answering the question **"Is information on service provision available in Greek",** the respondent reported that provider hospital supply patient literature in several languages.

The respondent reported that **health promotion materials are available in Greek,** but failed to give any specific examples.

According to the respondent the Health Authority is **providing resources** for an interpreting/advocacy/link work service, but failed to provide evidence about the amount of this resource.

Again according to the respondent the Health Authority includes **specifications in their contracts,** which ensure that the services it purchases are responsive, appropriate and acceptable to the Greek Cypriot clients. The respondent failed to give details as to how these specifications are monitored.
The respondent reported that the Health Authority **commissions adequate services** to deal with the needs of the growing number of Greek Cypriot elderly, but failed to give examples.

The same response is given when it comes to the services for the Greek Cypriot women.

The respondent failed to answer the question **"Does your organisation provide training for its staff to enable them to purchase/commission culturally and linguistically sensitive services for the Greek Cypriot population".**

No further suggestions or comments were offered.

DISCUSSION OF COMBINED FINDINGS

It is important to state at this point that the questions used to obtain data from providers and purchasers were based on the purchaser's own value statement, which commits them to respect for individuals, equity, choice and acceptability, information, partnership and consultation with local public, relevant and appropriate services (NRHA and E & H FHSA, Health Strategy, 1994).

The Purchaser's responses were unspecific and provided little information about their plans and contracts which related to the Greek Cypriot community. Although the Purchaser reported positively to many questions his/her failure to provide examples and specific information has led me to speculate that s/he was either not aware or not able to articulate this specific component; in either of these cases, this failure transmits a very negative message and indicates how low on the list of priorities, the issues which may concern the Greek Cypriot community are, which, as stated in Chapter 3, is the largest minority in Enfield and Haringey. It is of concern that the respondent failed to state whether or not the Health Authority has a health status profile for the Greek Cypriot community. I have analysed a number of HA documents and HA/LA joint documents (Annual Health Reports 1992-1996, NRHA Sector Profiles 1993, Haringey's Community Care Plan 1992/93, 1993/94, Combined Enfield HA, E & H FHSA and London Borough of Enfield Community Care Plan 1993/94, Health and Race Pack 1994, Health Strategy 1994/99, Business Plan 1994/95, E & H Primary Care Development Programme for Action 1994/99,

Strategy for Commissioning Health Services for Older People in E & H 1995, Communications and Corporate Development Strategy 1995, Purchasing Plan 1996/97, Primary Care Strategy 1996, E & H Patient's Charter Annual reports 1992/93, 1993/94, 1994/95) and found no evidence of the existence of a health status profile for the Greek Cypriot community, or any attempts of compiling one although reference is made to the available OPCS statistics about the number of households *'headed by'* Cypriots (includes Greek and Turkish) . There were very few references to services which have been specifically designed to deal with the health needs of this community or are being planned; the exception as usual is the reference to thalassaemia services, an alcohol study involving Cypriots (both Greek and Turkish) in 1992 (Theodorou 1992), and the funding of two Greek speaking link workers. Therefore it can be concluded that crucial information about the Greek Cypriot community is not available which must make the planning, purchasing and providing processes, impossible tasks. It could be argued that this evidence, renders the respondent's statement that the Health Authority commissions adequate services to deal with the needs of the growing numbers of Greek Cypriot elderly, invalid, particularly as the providers did not think so either. It is true that the Health Authority contract specifications have a few statements which refer to the services being appropriate and acceptable to people from minority ethnic communities but these are not specific to the Greek Cypriot community. However, his/her failure to state how these are monitored, reinforces the views of the providers that these specifications are not rigorously monitored. A crucial component of any level of change towards the purchasing and provision of culturally sensitive services, is the level of staff development; the respondent failed to answer this question.

The responses of the three providers appear to be frank and on the whole, detailed. They appear to be in a continuum of cultural awareness and action. Provider 1 seems to be the least culturally sensitive provider; Provider 3 is the most pro-active and culturally sensitive whilst Provider 2 is somewhere in between. Provider 1, with the exception of their plans to employ a nurse specialist/counsellor for thalassaemia, and the sessional use of link workers, declared that they had no information about the Greek Cypriot community and were not providing any services which were targeted

specifically for this community. This Provider reported that the Purchaser has not identified any needs, indicating that this was due to lack of project/focus groups being set up. This is a serious situation, one that shows that both the Purchaser (as argued above) and this Provider assume that this community group has no needs, and despite representing 6.9%-9.5% (or even higher percentage, the statistics vary), no strategy exists to ensure that the values of the Health Authority are upheld for this community group.

Provider 2, seems to have some awareness of the needs of the Greek Cypriots, perhaps because the community is represented at the provider's patient forum, or because more of their patients are Greek Cypriots, or perhaps because the two Greek Cypriot link workers are closely associated with this Trust. However, they too, made references to the responsibilities of the Health Authority to lead and provide information; they also implied that their services depended on their contracts, in other words they provided the services which the Health Authority wished to purchase. This Provider indicated that they expect to be given information either by the Health Authority or the Greek Cypriot community; this is a very passive position. Naturally the Greek Cypriot community has a role to play, but this needs to be part of a collaborative plan; the Greek Cypriot community, will be happy to be consulted but it lacks a coherent approach to collecting and presenting information which is regularly updated for use by the various statutory bodies. Such activities need money and leadership; currently there is neither. There are numerous organisations most of which have a social function, some exist to promote Cyprus, and some are related to education. The Greek Orthodox Church, is probably the only institution which has the structure and funds to collect statistics and although it does, it is primarily for its own consumption.

Provider 3, was probably much more geared towards the needs of the Greek Cypriot community. Those who completed the questionnaire gave detailed answers which painted a fairly clear picture of their provision. Although the various services varied in their approach and ability to provide, recognise and respond to need, their standards compare favourably with the *'Core Health and Race Standards for Acute*

and Community Providers' which were developed by the King's Fund London Health and Race Purchasers Forum (Silvera et al, 1996) and were published at the time of writing this thesis.

The evidence which was supplied by both the Purchaser and the Providers indicate the need for staff development, the need for more information about the Greek community -ideally the compilation of a health status profile- and the need for the development of local standards which address the needs of the Greek Cypriot community, and which they are regularly reviewed and rigorously monitored. The *'Core Health and Race Standards for Acute and Community Providers'* (Silvera et al 1996), are included here as a useful guide. The King's Fund Purchasers Forum believed that the core standards represent a baseline, which all providers should be achieving and which they should be extending to reflect their local needs.

1. *Ethnic monitoring of patients*:

1.1 Ethnic monitoring of patients should be undertaken for *all* services.

2. Religion:

2.1 Ensure that cultural and religious beliefs are appropriately observed.

2.2 Provision of multi-faith facilities for inpatients with information for patients about their availability, translated in required languages.

3. Communication:

3.1 Patients should be able to communicate with health workers in the language they feel comfortable with.

3.2 Services which patients may need to use should be clearly sign posted, enquiry points clearly marked, and essential written information regarding the services made available, in the community languages specified by the purchaser.

4. Patient choice:

4.1 Patients should have the choice of a female clinician and information made readily available regarding this option.

4.2 Single sex facilities to be provided wherever feasible.

5. Diet:

5.1 Meals should meet the cultural requirements of service users and be authenticated by the relevant community leaders.

5.2 Dietary information should be available to suit differing local community cultural requirements both in hospitals and in the community.

6. Staffing:

6.1 Ethnic monitoring of all staff to be undertaken.

6.2 All staff involved in providing services should be fully aware of how the Health and Race Standards relate to their areas of work.

7. Patient complaints:

7.1 Ethnic monitoring of complaints should be introduced and maintained.

COMMUNITY HEALTH COUNCILS (CHCs)

The views of the two CHCs, whose function is protect the rights of the public through consultation, provision of information and investigation of complaints, were sought. Both reported that they do not routinely collect ethnicity data, although one of the two recorded the ethnicity of the persons, whose complaints they investigated. The views of one of the senior officers were that Greek Cypriots' needs were no different from everyone else's and that they complained in the same way as everyone else did. When they represented individuals ***"...their ethnicity was not important; people are all the same; they all want to be treated like human beings"***. The senior officer from the other CHC, stated that one of the executive members is a Greek Cypriot and any specific issues are usually raised by her. She mentioned that they provided leaflets in Greek and that in the previous year they had commissioned a

survey which investigated users views of the maternity services and that Greek Cypriots were included in that study. During 1992 this CHC investigated 102 complaints, 6 of which were from Greek Cypriots. In 1993 (January to November) they had investigated 105 complaints, 5 of which were from Greek Cypriots. In this officer's view some Greek Cypriots had a communication problem but their complaints were not ***'culturally based'***. This officer was generally positive about the work of the Health Authority (HA). On the other hand the officer from the other CHC was very critical of the Health Authority. She said that they sit on the Health Authority Committee, but this was a purely cosmetic exercise. ***"Our views are never listened to or respected by the Health Authority who think they know everything. One of my colleagues has just returned from a HA quality meeting totally frustrated saying that 'they' talked among themselves without taking any notice of the CHC member".***

SUMMARY

In this chapter the findings of the survey of the views of health purchasers and providers in Enfield and Haringey regarding the health needs of the Greek Cypriot community were reported and analysed. The views of two senior members of the Enfield and of the Haringey Community Health Councils were also reported. The findings revealed that the expressed insights into the health needs of this community as well as the actual provision of services ranged from poor to an acceptable level.

The next chapter synthesises and critically reviews the main findings of this study.

CHAPTER 10

INTERPRETATION OF FINDINGS

INTRODUCTION

This study set out to investigate the health beliefs, lifestyle behaviours and health status of the Greek Cypriots living in two London Boroughs, and to compare these, where possible, to the majority of the population. Based on evidence from studies of other minority ethnic groups, it was assumed that some differences exist. The study also sought to investigate whether or not health professionals were meeting the health needs of this minority ethnic group. Again, based on the findings from other studies around the health of minority ethnic groups, it was assumed that at least some of the needs are not being met. The literature which was reviewed in Chapters 5 and 6, indicates a number of reasons for this such as:

⇒ lack of nationally generated information and research evidence (Hopkins 1993, Smaje 1995);

⇒ lack of, or ineffective dialogue with the public for locally generated information / knowledge (Donalson 1995, Hogg 1995);

⇒ failure to take into account the cultural elements of health (Leininger 1983, 1991, Helman 1990);

⇒ inappropriate, insensitive care (King's Fund 1990, Audit Commission 1992)

⇒ language barriers which result in poor communication and failure to access services (Hopkins 1993, Dale 1995);

⇒ direct discrimination and institutionalised racism (McNaught 1987, CRE 1991, Ahmad 1993);

⇒ failure to equip health practitioners with relevant knowledge and skills (Kushnick 1998, Papadopoulos and Alleyne 1995, Gerrish et al 1996);

⇒ high levels of deprivation resulting in a multitude of problems related to unmet health needs (Benzeval et al 1992, Kurtz 1993, Benzeval et al 1995, Oppenheim and Harker 1996);

⇒ negative effects of social exclusion (Coote 1992, Whitehead 1995, Wilkinson 1996).

Due to the dearth of information about the health needs of the population under study, a number of approaches were employed (Chapter 2) in order to generate data which would enable the investigation to refute or substantiate the assumptions made. As mentioned above, one of the main aims of this study was to gain an understanding of the group's health needs and to compare these were possible to other similar studies. This was done by enquiring into their health beliefs, lifestyle behaviours and self reported health status, through interviews and a health and lifestyle survey (Chapters 7 & 8). Data obtained from the survey were compared with the Health Survey for England 1991 (White et al 1993) and the Newcastle Health and Lifestyle Survey 1991 (Harrington et al 1993) in an attempt to identify differences between this group and the population of the two studies.

Another aim of the study was to find out the extent to which, the actual and felt health needs of the Greek Cypriots under study, were known and/or understood by the health providers and purchasers, and to assess whether they were responding to these in a culturally competent way. This was done by analysing a number of documents for relevant information, statements about health problems and needs of this group, as well as plans for action; the views, level of understanding and practice, of a number of relevant providers and purchasers of health services, were surveyed through interviews and a self completed questionnaire (Chapters 3, 6 & 9).

This chapter attempts to bring together the findings, to discuss their significance in terms of current policy and practice, and to draw some conclusions. As was discussed in the introductory chapter, many changes have taken place since 1996 when the bulk of this study was completed. Whilst it is believed that this study has made a modest contribution in the area under investigation, it is important to remind

the reader that due to the limitations of the study, which were discussed in Chapter 2, some of the findings must be viewed with caution. For example, the near absence of demographic, epidemiological and cultural data related to this community, meant that only very limited comparisons could be made between the findings of this study and findings from other health related studies about this minority ethnic group. For a number of reasons, which were discussed in Chapter 2, the study has an age, gender and generation bias which inevitably has an impact on the findings. However, despite the limitations, the underpinning theoretical framework and the findings of the study appear to be relevant to many of the current NHS changes.

In trying to identify an effective way to deal with the volume of findings which were derived from different sources, using different methodologies, the following conceptual model (Table 10.1) was constructed and used. The themes running down the first column represent the major areas of the investigation which relate to the Greek Cypriot people living in the London Boroughs of Enfield and Haringey. Findings from these themes are reviewed against the three horizontal areas which deal with current evidence and provision, as well as future policy and practice.

Table 10.1: Conceptual model used for the interpretation of findings

The Greek Cypriot people	*Findings and comparisons with other studies*	*Current health professionals' understanding and service provision*	*Implications for policy and practice*
Beliefs about health and illness			
Health and illness knowledge and views			
Self assessment of health status			
Health enhancing and harming behaviours			

BELIEFS ABOUT HEALTH AND ILLNESS

Findings and comparisons with other groups: *Health beliefs*

The findings in Chapter 7 reveal that first generation Greek Cypriots tried to retain their cultural beliefs and practices as a means of surviving in a foreign and often hostile country. They had internalised the notion of being inferior to the *'English'* people who had ruled Cyprus, before they arrived in England. It seems that this attitude of subordination which they had come with and which was regularly reinforced by the behaviour of English people towards them, led them to be either grateful for everything the health system provided for them or be suspicious about it and even sometimes to rebel against it by being too demanding. In order to survive, those who migrated to England during the first half of this century, created their own networks which centred around the family, the church and the places of employment. Thus family, religious and work values provide the backcloth for their values and beliefs around health. The process, experience and impact of migration for the Greek Cypriots is not dissimilar to those of other ethnic groups, and form an important part of personal and group identity which affects lifestyles and health (McNaught 1987).

Irrespective of age, generation or gender, the participants reported similar beliefs about health and illness. The only noticeable difference was that the female participants from both generations made more frequent references to religion.

The Greek Cypriots who were involved in this study believe that keeping healthy is a matter of mental attitude (*'nous'*); a positive attitude to life keeps one healthy whilst a negative one makes one sick. Each individual is considered able to control their life and make their own decisions to promote or harm their health. The participants believe that eating a healthy diet, taking exercise, going to work and visiting friends are important to health. Having a family is a source of health, as members can give *'tharos'* (support) to each other. They also believe that health is *'strength'* and link this to age and ability to work or perform one's social roles. Strength was not seen as purely physical but also spiritual. But, whilst a belief in God gives people strength, it also gives them a somewhat fatalistic attitude to health, in as much as they believe that whatever they do God will look after them, or that there is nothing they can do

as the illness may be a punishment from God. We therefore observe a continuum of beliefs; on the one end there is the autonomous, self determining individual whilst at the other end there is an individual with fatalistic beliefs.

When comparing the health beliefs of the Greek Cypriots with those reported in other studies, certain similarities are found. Stainton Rogers (1991) identifies eight distinct but inter-related lay theories for health and illness. Echoes of four of these theories are found in the beliefs of the Greek Cypriots. Her *'health promotion'* theory stresses the wisdom of adopting a healthy lifestyle, similar to the Greek Cypriots belief about health eating and exercising. This belief is also similar to what Blaxter (1990) describes as the *'healthy life'*. Stainton Roger's theory of the *'robust individualism'* which is concerned with the individual's right of freedom to choose how to live their lives, and the *'willpower'* theory which stresses the control that an individual has to maintain his/her health, are similar accounts to those expressed by the participants of this study. Her *'God's power'* theory is similar in terms of God's care, although in the Greek Cypriots' perception, there exists a contradiction: God is fair and just and will sometimes punish them for their wrong doings with ill health, but God is also benevolent and will care for them whether they do the *'right'* or *'wrong thing'*. The explanation of health as strength has also been offered by Sacks (1982), McCluskey (1989), Williams (1983,1990) and Howlett et al (1992). Blaxter (1990) differentiates strength in three ways: *'as a reserve'*, as *'energy and vitality'* and as *'physical fitness'*. The functional explanation of health found in this study, has also been described by many others (Parsons 1981, Blaxter and Patterson 1982, Williams 1983, 1990, Rosenbaum 1991, Howlett et al 1992, Lambert and Sevak 1996). Finally the belief in the healthy influence of social structures such as family and friends has been described by Blaxter (1990) as *'health and social relationships'* and *'health as psycho-social well being'*. Benzeval et al (1992), report that there is a link between social isolation or deprivation and ill health, whilst Wilkinson et al (1998) suggest that people with good social networks live longer and have healthier lives.

Perhaps the major difference between the findings of this study, in terms of health beliefs, and those reported by many other researchers, is that the Greek Cypriots do not explain health in terms of *'not being ill'* or despite of suffering from a chronic

illness (Herzlich 1973, Blaxter and Patterson 1982, Calnan 1987, McCluskey 1989, Williams 1990, Blaxter 1990).

Findings and comparisons with other groups: *Illness beliefs*

The majority of the Greek Cypriots who participated in this study believe that the major cause of ill health is stress. A rich vocabulary is used to describe different types and levels of stress. For example, the *'stress type continuum'* may have *'monaxia'* (loneliness) on one end and *'marazi'* (sadness and depression) on the other. The *'stress level continuum'* may have *'stenochoria'* (feeling of being squeezed in a narrow space) on the one end, and *'anghos'* (choking feeling) on the other. Stress is not seen as something to be stoically endured or as anything which has a positive aspect to it. Stress is definitely something to be avoided or be got rid of, as quickly as one can. Learning how to get rid of stress was one of the top three answers given when asked to list the topics which they would like to know more about. Lambert and Sevak (1996), in their study on perceptions of health and illness among Londoners of South Asian origin, found that stress was cited as cause of illness by all their informants. However, unlike the Greek Cypriots, they characteristically reported that the English words were most frequently used even by those who did not speak English. One of Stainton Rogers (1991) theories of health and illness is the *'body under siege'* in which the individual is seen to be under threat and attack from germs and diseases, interpersonal conflicts and the *'stress'* of modern life acting upon the body through the mind. Blaxter (1990) in her analysis of the national Health and Lifestyle Survey (Cox et al 1987) reported that respondents identified stress as the fourth major cause of illness.

Poverty is also believed, by some respondents, to be a major cause of ill health. For example, a woman explained that her arthritis gets worse in the winter because she can not afford to heat the house for more than four hours per day. Another respondent suggested that poverty often leads to arguments and conflict within the family. This finding is no surprise, as, since the issue of poverty was raised in the Black Report (Black et al 1980), the link has been identified and confirmed by other studies (Whitehead 1987, Ahmad et al 1989, Benzeval et al 1995, Drever and

Whitehead 1997) and has been recognised by the World Health Organisation (*Targets for Health for All*, 1985) and the British government, in major policy papers such as *'Our Healthier Nation: A contract for health'* (DoH 1998), and the report of the *'Independent Inquiry into Inequalities in Health'* (Acheson 1998).

Many Greek Cypriots who took part in this study reported that much ill health is self inflicted. They inverted many of their health beliefs cited above, to become illness beliefs, such as eating too much, or working too hard causes ill health. They have also described themselves as *'risk takers'* or *'living dangerously'*. This may have something to do with their earlier convictions that individuals can decide for themselves how they wish to live their lives, and it seems to be associated with the belief that they can find ways to treat themselves or obtain the best cures, either through the NHS, or through private medicine. Perhaps these beliefs portray hedonistic people, who value their enjoyment more than illness prevention or health promoting activities. Some of my informants suggested that these beliefs stem from the Greek Cypriots ethnohistory and migration experiences. The early immigrants left Cyprus to escape poverty. For the majority, life in England did not reach their expectations and as a consequence they treated their stay as temporary. They aimed to become financially independent as fast as possible, by working long hours or by taking chances in business (Anthias 1992). Having more money, enabled them to start enjoying life, but also, it appears, it gave them a false sense of security, in, for example, believing that money will buy them cures when, or if, they need them. Another possible explanation of the notion of self-inflicted ill health may be through the *'victim blaming'* theory. It may be that the Greek Cypriots have internalised the prevailing politic of *'lifestyles'* which explains ill health in terms of individual behaviour and places particular emphasis on *'culture'*, thus blaming the individual - particularly those of minority cultures-, for his/her own health problems (Crawford 1977, Pearson 1986, Ahmad 1989, 1992, 1993). For example, it was characteristically reported in Chapter 7, that Greek people have become greedier as they have become relatively wealthier and that this phenomenon is also happening in Cyprus. The person making this observation, clearly linked ill health to a *'Greek Cypriot'* characteristic of being greedy, thus blaming the individual Greek Cypriots

for their ill health. Another example comes from the health providers who were interviewed for this study. They implied that Greek Cypriots frequently did not comply with professional advice mainly due to language problems. It is probable that they saw this as a problem of the Greek Cypriots and thus any subsequent ill health was due to a cultural-linguistic barrier. As was discussed in Chapter 5, the practice of victim blaming, was a result of *'multi-culturalist'* explanations of ill health, which was severely criticised by the *'anti-racist'* exponents. Clearly, as discussed above, whilst health and illness beliefs may be influenced by a person's cultural background, those who participated in this study have offered beliefs which relate to the socio-economic status of individuals, such as poverty, which may be the result of discriminating and racist societal structures rather than a state of being which is culture dependent.

According to many of the participants of this study, family is seen as a force for health but also as a cause of ill health. Examples which were given, include inter-generational conflicts between parents and children, role conflicts between married couples, financial problems within the family and divorce. It was suggested that all these cause stress which may lead to unhealthy behaviours such as excessive smoking and drinking, may lead to anxiety, depression and other forms of mental illness, or may be somatised and expressed as physical illness. McGoldrick et al (1991) describe similar family stressors among refugee families. Fox (1991) reports on spousal conflict among Vietnamese refugees as a result of wife employment. Helman (1990) suggests that families are cultural groups, with their own view of the world, their own codes of behaviour, their own gender roles, concepts of space and time, their private language, own history, myths and rituals. They also have ways of communicating psychological distress to one another and to the outside world. This family culture can be either protective or pathogenic of health. It is to be assumed that Helman would use *'the culture analogy'* to explain protectiveness and pathogenicity; that is to say that like culture, family is a dynamic and ever changing concept, and that some members of the family are more able to adapt to the changes than others. Other theorists suggest that illness patterns within the family are the result of genetic inheritance. Stunkard et al (1987) refer to obesity, Cloninger (1987) refers to a predisposition to addiction, whilst Bewley and Bland (1977) refer to

smoking. It is noticeable that the only genetic link made by the Greek Cypriots of this study, was without exception that of thalassaemia, an inherited blood disorder.

Current health professionals' understanding and service provision

In this study health service providers were aware of genetic inheritance and were providing a range of services linked to thalassaemia: genetic counselling, thalassaemia screening and of course treatment for those unfortunate enough to need it. The contribution of religion to health and illness beliefs was acknowledged by one provider who specified that the Greek Orthodox priest are allowed open access to patients. References were made by the same provider that some health promotion leaflets are available in Greek. However, although language difficulties is one of the very few specific needs referred to by two of the three providers and indirectly by the purchaser who took part in this study, purely translating information into Greek may not be the most appropriate way to deal with health promotion. As discussed in the previous section, the health and illness beliefs of the Greek Cypriots bear many similarities to those of other groups; there are also subtle differences which are currently not being considered. Lambert and Sevak (1996) state that,

> *'...health education that concords with lay people's views about the causes of ill health may be readily accepted....'*
>
> (p 151)

Many of the Greek Cypriots who were interviewed for this study praised the health professionals. For example, a woman who had undergone a series of surgical operations reported that the doctors were very good, that they worked very hard and that they have to deal with a lot of pressures. Nonetheless, some interviewees provided examples which indicate lack of understanding on behalf of the health professionals. They reported that nurses made negative comments about the presence of large members of the family around the bed; this may be seen as an illustration of their ignorance about the importance which Greek Cypriots attach to family for providing *'tharos'*, a force of health, and of *'monaxia'* (loneliness), as a

cause of ill health. Lack of understanding on behalf of the health professionals, may be a possible explanation of the suggestion made by the Greek Cypriot participants of this study, that more Greek Cypriots should enter the health professions; their reasoning for this was that such people would have similar experiences and will hold similar values, thus being able to understand them better and empathise with them.

The documentary analysis identified general statements about respecting individuals' cultural beliefs, but no examples could be found which illustrated awareness of the Greek Cypriots' health and illness beliefs or any attempt to identify them. Whilst the documents lack information, the evidence given by some of the health providers in this study, suggests that they have certain level of understanding. It is debatable, however, that this alone would result in the relatively high level of user satisfaction reported above. Other explanations need to be searched for, such as: the existence of low levels of user expectations; the ability of health care providers to effectively use generic caring skills such as listening; or their possession of caring characteristics related to the notion of *'human dignity'* (Wilkinson 1996), a universal value which underpins equality and justice; or perhaps a possible explanation may involve a combination of all the above.

Implications for policy

Currently, *'Health Improvement Plans'* are being developed across the country. These will bring together a gamut of plans from various statutory and non-statutory sectors dealing with most of the recognised health determinants. Four national priority areas for health improvements have been identified: cancers, accidents, heart disease and stroke, and mental health. Local priorities are being identified by the newly formed *'Primary Care Groups'*. *'Clinical Governance'* arrangements are being implemented, and locally developed *NHS Charters* are around the corner (Dyke 1998). The government aims to improve the health of the population and to narrow the health gap between the better off and the worst off in society. Underpinning all these changes is the notion of *'partnerships'* between agencies and sectors, and the involvement of local communities. It is clear that demographic and epidemiological information is needed. This, however, needs to be supplemented by a good

understanding of socio-economic and cultural determinants of local groups. As suggested in this thesis, culture contributes in shaping of identities, whether real or imagined, whether collective or individual. Crucial component of cultures are the values and beliefs encompassed within them, which although not static, are nevertheless important to health and health provision and should be considered in needs assessment, resource allocation, health care planning and provision (Acheson 1998).

It would therefore seem to be imperative that the Greek Cypriot community collaborate with policy makers, planners and practitioners to bring about this understanding. But although the government has presented the idea of *'partnerships'* as the process to democratise decision making in the NHS, Tsouros (1990) in reference to *'community participation'* within the World Health Organisation's Healthy Cities initiative, has described it as one of the most problematic areas of the initiative due to:

1. lack of understanding of what the term meant,
2. a level of confusion about how to achieve it,
3. the resistance by politicians, professional and managerial groups to accept the views of community representatives, and,
4. a lack of resources that adequately supported and encouraged community participation.

Petersen and Lupton (1996) have argued that participation often amounts to little more than tokenism, where people may be consulted but have no real power to affect decisions. According to them participation is couched in terms of citizenship obligations rather than rights, something which once again places the responsibility on the individual to do the right thing. They have questioned the proposition that participation will increase democracy since much of the decision making is still being carried out in a culture that is dominated by rational, science-based expertise and bureaucratic structures. They go on to say:

'There is no acknowledgement of the fact that different individuals and groups have varying degrees of "freedom" to fulfill their participatory responsibilities and obligations. Many of those who have been the target of participatory strategies live in disadvantaged circumstances that make it difficult to attend regular meetings or to become involved in activities that entail financial outlays and so on; they may not enjoy even the basic rights, such as the right to work and to shelter....Despite its egalitarian overtones, "participation" is always contingent upon some "trade-off", whereby, clearly, some have a lot more to trade with than others'.

(pp161-162)

It is therefore clear that participation is a contested concept as well as being an unproven process. Furthermore, it appears that the health policy experts operate under the assumption that there is an objectively existing *'community' 'out there'* that can be readily defined, located and engaged in the participatory processes. In terms of the Greek Community, the presence of a Greek Cypriot person on a *'patients forum'* was referred to by one provider. But how effective is such representation? The first Enfield and Haringey Health Improvement Plan was prepared and agreed by a large committee which included representatives from five umbrella organisations of the voluntary sector. Because of the short time scale available, the membership of the umbrella groups (which would have included a Greek/Greek Cypriot organisation) was not consulted. But even if time did permit this to happen, groups and individuals would have had to read a vast number of documents and would have needed guidance to understand the complexities of what was required of them.

It was argued in Chapter 5 that the current focus on reducing inequalities in health by promoting inclusive strategies, was more preferable than either the multi-culturalist or the anti-racist approach. Rather than dismissing the sceptics such as Petersen and

Lupton (1996), those concerned with health policy need to heed their analyses and act to avoid the problems they have identified. It could therefore be concluded that to achieve an effective dialogue with local communities and thus a reasonable level of partnership, it would take time, some experimentation and a fairer distribution of power and resources.

Implications for practice

The findings of this study cannot be seen as definitive in terms of providing an understanding of the level of knowledge of the health and illness beliefs of the Greek Cypriots that health professionals may have. It appears that on the whole, those who participated in this study were either happy with the care they received, or were able to justify the care which fell below their expectations, by stating that doctors, for example, do not have the time to learn about every ethnic group in their constituency. Research evidence from other studies which have been cited in this chapter, points out that lay health and illness beliefs are just as important explanations as those derived from biological and medical studies. Furthermore, as discussed in Chapter 5, much of the evidence todate, concludes that people from minority ethnic groups, frequently receive care which is insensitive, inappropriate and at times racist.

Le Var (1998), agrees with others (Audit Commission 1992, Papadopoulos et al 1994, Gerrish et al 1996) that nurses are failing to provide culturally sensitive care to people from diverse cultures, and that one of the reasons for this is the lack of adequate preparation during training. It is argued that there is a need for the development of both knowledge and relevant transferable skills. In an attempt to address this deficit, a model has been proposed by myself and two colleagues (Papadopoulos, Tilki and Taylor 1998) and it involves the following stages:

CULTURAL AWARENESS
*Self awareness
*Cultural identity
*Heritage adherence
*Ethnocentricity

CULTURAL COMPETENCE
*Assessment skills
*Diagnostic skills
*Clinical Skills
*Challenging and addressing prejudice, discrimination and inequalities

CULTURAL KNOWLEDGE
*Health beliefs and behaviours
*Barriers to cultural sensitivity
*Stereotyping
*Ethnohistory
*Sociological understanding
*Similarities and variations

CULTURAL SENSITIVITY
*Empathy
*Interpersonal/communication skills
*Trust
*Acceptance
*Appropriateness
*Respect

A conceptual map is provided for each stage as a guideline only. Educators who are well versed in this area of learning may add other concepts or modify the proposed ones to suit the type and level of students. The first stage in the model is cultural awareness which begins with an examination of our personal value base and beliefs. The nature of construction of cultural identity as well as its influence on people's health beliefs and practices, are viewed as necessary planks of a learning platform. Cultural knowledge (the second stage) can be gained in a number of ways. Meaningful contact with people from different ethnic groups can enhance knowledge around their health beliefs and behaviours as well as raise understanding around the problems they face. Through sociological study the students can be encouraged to learn about power, such as professional power and control, or make links between personal position and structural inequalities. An important element in achieving cultural sensitivity (the third stage), is how professionals view people in their care. Dalrymple and Burke (1995) have stated that unless clients are considered as true partners, culturally sensitive care is not being achieved; to do otherwise only means that professionals are using their power in an oppressive way. Equal partnerships involve trust, acceptance and respect as well as facilitation and negotiation. The

achievement of the fourth stage (cultural competence) requires the synthesis and application of previously gained awareness, knowledge and sensitivity. Further focus is given to practical skills such as assessment of need, clinical diagnosis and other caring skills. A most important component of this stage of development, is the ability to recognise and challenge racism and other forms of discrimination and oppressive practice. It is argued that this model combines both the multi-culturalist and the anti-racist perspectives and facilitates the development of a broader understanding around inequalities, human and citizenship rights, whilst promoting the development of skills needed to bring about change at the patient/client level.

HEALTH AND ILLNESS KNOWLEDGE AND VIEWS

Findings and comparisons with other groups

The Greek Cypriots who took part in this study were found to have a good general knowledge of the factors which cause ill health. However, those aged 65+ were more likely to have lower levels of knowledge than those below this age, whilst those with higher levels of education had higher levels of knowledge. Despite the good general knowledge, this did not result in healthier eating, lower levels of smoking or higher levels of physical exercise. As can be seen in the following paragraph, their specific health knowledge was relatively poor.

Participants correctly identified that eating too much fatty food, having high blood pressure, smoking cigarettes and too much stress, contribute towards the development of heart disease. They identified that smoking causes lung cancer, bronchitis and heart disease, and most of them (n=60 out of 142 who responded) reported that ill health could result from smoking between 1-5 cigarettes per day. However, a large number (n=43 out of 142) reported that one needs to smoke between 11-30 cigarettes per day before risking their health. Although they correctly linked alcohol to liver cancer, health problems resulting from car accidents, high blood pressure and stomach cancer, their knowledge of safe alcohol limits was very poor and was illustrated by their responses which ranged from 0-100 units per week. Despite identifying the correct links between diet and ill health, the findings indicate

that their diet remains high in intake of red meat, cakes and hard cheeses. Fifty per cent of women and 36% of men are either overweight or obese.

Blaxter (1990) reports that 84% of her respondents linked smoking to cancer of the lungs, whilst 53% of them linked it to bronchitis. She too reports that a majority of the Health and Lifestyle population associated heart disease with smoking, diet and stress, whilst liver disease was linked to an excess of alcohol. Similarly, she reports that knowledge did not correlate with behaviour except in the case of younger people who stressed the importance of diet in disease causation and who tended to have healthy diets. On the other hand, Backett and Davison (1995) reported that although younger people were aware of the problems which fatty foods, smoking and drinking may eventually cause, they did not consider them important to avoid since they believed that active, busy or even sporty life would *'burn off'* any bad effects. Bhopal (1986), found that the older informants in his study of 65 South Asians living in Glasgow, who were also less familiar with the English language, had poor knowledge about the risk factors for heart disease and about the dangers of alcohol.

Current health professionals' understanding and service provision

As has been stated several times in this thesis, neither the health purchasers nor the health providers had developed a health status profile of the Greek Cypriot community. Unfortunately the survey of the purchasers and providers (Chapter 9) did not explore in any detail their understanding of the Greek Cypriots in terms of health and illness knowledge. Information from other sources is very sparse. In this decade, only three studies which examined aspects of health of the Cypriot community in Enfield and Haringey were commissioned:

a) Abdulrahim et al (1994) studied ethnicity and drug use in Haringey. The study was funded by the then North East Thames Regional Health Authority and part of it included a focus on the Cypriot community (Greek and Turkish). They found that many Cypriots denied that drugs affect the *'community'*. This denial is linked partially to the cultural construction of drug use and to the stigma that drugs bear within the community. Denial can also

be located within the fear of being associated, as a minority ethnic group, with drug use, and that it may bring additional discrimination. They also found that parents often lacked the necessary understanding, knowledge and skills to tackle drug related issues. One of the reasons for this was due to language problems. Despite the fact that Cypriot parents were often not able to support their children, Cypriot children were more likely to turn to their parents than to other adults for support. The researchers recommended that it is essential that all drug workers are formally trained to consider issues relating to the cultures of their clients and that at least some of them should be able to communicate with clients in their language.

b) Theodorou (1992) had, on behalf of the Health Authority, carried out a study on the alcohol needs and attitudes of Cypriots (Greek and Turkish) living in Haringey. She found that nobody in the sample aged 61-79 years had full awareness of the recommended limits. Only 27% of those aged 15-30 years had full awareness whilst 40% of those aged 31-60 had full awareness of safe alcohol limits. In addition she found that the Cypriots who took part in her study believed their alcohol problem was nothing in comparison with that of the host community.

Unfortunately, having analysed a number of key documents of the E&H HA and community plans, it appears that neither the findings nor the recommendations of these two studies had any impact in terms of raising professionals' understanding or in terms of service provision.

c) Papadopoulos and Worrall (1996) were funded by the E&H HA to examine the primary health needs of the Greek and Greek Cypriot women living in Enfield. They reported a very unsatisfactory picture in terms of health professionals' understanding of the womens' personal health and illness views. Poor communication, due to language and cultural barriers, was at the heart of this lack of understanding. Some women reported avoiding going to their doctor, adopting instead a range of different strategies to deal with their

health problems, such as paying to see a doctor of their choice, treating themselves, or even obtaining treatments from Cyprus. One of the main recommendations of that study, was the urgent need for training of health professionals around the Greek Cypriot culture, which, as the study reported, contributed in the way Greek Cypriots reacted to illness. However, a follow up study aimed at providing such training, failed to be funded by the Health Authority, as it was not perceived as a priority area.

Implications for policy and practice

Knowledge of health and illness, like any other type of knowledge, is not constructed in a vacuum. It is the product of a complex interaction of an individual with his/her environment. Personal characteristics such as biology, stage of development, education, socio-economic position and culture, exists within a particular place, time, political and other systems. Increasingly, local and global media are influencing all aspects of life.

Murray (1997) suggests that popular and professional systems interact so that the lay person can draw upon specialised knowledge while the professional can make use of popular knowledge. Morgan (1996) suggests that whilst both ways of thinking are located within a particular local and political context they both draw upon a larger world view. Popay et al (1998) on the other hand, believe that lay knowledge differs from expert knowledge in the sense that it has an ontological purpose, orienting behaviour in terms of an understanding to the individual's place in their life-world. They argue that lay knowledge is expressed in narrative form which is antithetical to traditional models of cause and effect which dominate both medicine and the inequalities research literature. Stacey (1994) prefers the term *'people knowledge'* rather than *'lay knowledge'* and argues that the main distinction between professional knowledge and people knowledge is that the latter is most often experiential knowledge, but is just as complex as professional knowledge.

The health and illness knowledge found in the Greek Cypriots that participated in this study relates to all the above theories. On the one hand, the participants have a good understanding on what causes ill health; this is knowledge which is both experiential

and produced by *'health experts'* and is transmitted to them through the formal education system, their contact with doctors and through health messages being delivered by government policies and campaigns. At the same time, global health knowledge is gained through the inescapable consumption of mass media. All this acquired knowledge is particularised in terms of each person's beliefs and values. Radley and Billig (1996) call this process of thinking and knowing a *'socially shared activity'*.

The Greek Cypriots' lack of specific health knowledge and their failure to adopt healthy behaviours in general, maybe explained in terms of the previous discussion on *'risk taking'* or *'living dangerously'*. This may also represent a failure of policy makers and health professionals to have an impact on this, and other communities (Bhopal 1991, Smaje 1995). Pasick et al (1996) note that the first generation of health promotion studies assumed similarities across groups, with little awareness of potentially important differences. The second generation has been immersed in differences. However, to adequately and appropriately serve multi-cultural communities, the capability should exist to reach across populations when possible but to tailor as necessary. In terms of policy and practice, this is highly relevant to the issues concerning the need for a *'Health Status Profile'* raised in Chapter 6. It is also relevant to the renewed emphasis on involving local people in the development of local plans, such as Health Improvement Plans, which must reflect local needs. It appears that general health knowledge exists across populations but, at least in the Greek Cypriot community, health tailoring is not being achieved. To achieve this, policy makers and professionals must first engage in the parallel activity of becoming aware of the knowledge which already exists within the Greek Cypriot community; only then can they start to fill in the gaps through tailor-made programmes. It is important to note that 62% of the respondents of this study were women. Two factors need to be taken seriously:

a. that many of these women are isolated and,

b. that mothers have a major influence on the health beliefs and knowledge of their families (Blaxter 1982, Graham 1987,

Papadopoulos 1994, and Papadopoulos and Worrall 1996, see also Chapter 7).

SELF ASSESSMENT OF HEALTH STATUS

Findings and comparisons with other groups

Eighty-two percent of the respondents of the health and lifestyle survey reported to be very healthy or in reasonable health. Similarly, nearly 84% of the respondents consider themselves to be reasonably fit for their age. Those reporting ill or poor health and fitness tended to be in the older age group (55+, which constituted approximately 24% of the respondents). Nearly 29% of the respondents reported to be suffering from long-term illness. Of them, 30% reported to be suffering a heart related or circulatory condition. Other reported long-term illness included musculo-skeletal, respiratory, skin, and sensory problems, mental illness and cancers. The study also revealed that nearly 49% of the women and 36% of the men who took part, are overweight (average 42%).

The findings of this study revealed a variation in the way men and women define their health and fitness. Women tended to perceive these as reasonable much more frequently than men, whose scores were more evenly distributed. Gender difference in fitness definition was statistically significant (p=.02).

In 1997, 39% of the deaths in Enfield and Haringey were due to circulatory conditions. The 1991 Health Survey for England (HSE 91) found that approximately 77% of the population thought that their health was very good or good, whilst the Newcastle Health and Lifestyle Survey (NHLS 91) reported this to be approximately 80% and the Health Education Authority's *'Health and Lifestyle Survey'* (HEA 94) found this to be 81%. In terms of long term illness, the HSE 91 reported this to be 40%, the NHLS 91 reported it as 28%, and the HEA 94 found this to be 30%. In terms of body weight, the HEA 91 found that nearly 49% of the population was overweight; the NHLS 91 reported this to be 45%.

The comparisons show that slightly more Greek Cypriots reported to be in good health than in the other three studies. Fewer reported to suffer from long term illness than the general population of the HSE 91, but the figure is almost the same as that of the NHLS 91 and the HEA 94. Similarly the body weight figures of the Greek Cypriots who took part in this study, appear to be better than both the HSE 91 and the NHLS 91.

The findings of this study indicate that despite the Greek Cypriots' lack of specific health knowledge, their health status seems to compare favourably with that of other groups. Given the arguments around the reasons and explanations for ill health in minority ethnic groups which were discussed in Chapter 5 and were summarised at the beginning of this chapter, the question is, how can these findings be interpreted. Clearly, the participants' cultural beliefs influence their lifestyles, but other influences, such as their socio-economic status, cannot be excluded. Notably, the participants have reported a lack of understanding of their needs by the health providers. Although some of the evidence points towards discriminatory practice, the participants themselves did not overtly link unsatisfactory care to racism. The lack of nationally and locally gathered data about this minority ethnic group could be interpreted as a policy of exclusion. The existence of such a large Greek Cypriot community in Enfield and Haringey can in itself be reinforcing exclusion from the larger community but it may also function as an inclusive force nurturing and supporting individuals within its boundaries. Wilkinson (1996) argues that:

> *'At all stages in human societies, whether rich or poor, the quality of social relations has been a prime determinant of human welfare and the quality of life....it is the social feelings which matter, not exposure to a supposedly toxic material environment. The material environment is merely the indelible mark and constant reminder of the oppressive fact of one's failure, of the atrophy of any sense of having a place in a community,*

and of one's social exclusion and devaluation as a human being'.

(pp211-215)

The realisation of the importance of tackling social exclusion was behind the *'unified approach'* to eliminating inequalities of health and improving the health of minority ethnic groups, as discussed in Chapter 5. The majority of the Greek Cypriots who took part in this study, reported that they had good social support systems and that these were primarily within the family. The majority also reported to be satisfied with their social lives. Perhaps, the family and community networks which the Greek Cypriots have, compensates in some way for the effects of societal exclusion which they may suffer. Therefore, it could be argued that their ethnic identity has therapeutic properties. However, despite the favourable comparison of their health status with that of other groups and the general population, the fact remains that improvements need to be made. This point will be returned to, when a closer look at the government's attempt to reduce exclusion and marginalisation will be discussed under the implications for policy and practice section.

Current health professionals' understanding and service provision

This study is the first of its kind to produce data on the health status of this minority ethnic group living in Enfield and Haringey, and as discussed previously, national statistics for this group are very sparse and inaccurate. It is therefore doubtful that the health professionals would have adequate understanding; they would have knowledge of their individual patients, and some, such as the GPs may be making their own assumptions about the group of Greek Cypriots they care for. For example, one of the Greek Cypriot GPs who was interviewed commented that *'...one gets the feeling that the rate of heart disease is quite high...but there are no figures that I am aware of, so I cannot say if it is higher than the rest of the population'.*

In terms of service provision, the only specific *'medical'* services that have been identified are those related to thalassaemia.

Implications for policy and practice

Perhaps the most up-todate indicator of local policy and practice in this area is to be found in the Health Improvement Plan (HImP) (currently in its penultimate draft, March 1999) which Enfield and Haringey Health Authority in partnership with the London Boroughs of Enfield and Haringey, and with input from local Primary Care Groups, Hospital Trusts and a range of voluntary organisations, is developing for the period April 1999 - March 2002. The document states that in addition to the four national priorities (heart disease and strokes, cancer, accidents, and mental health) the local priorities which were identified in the Health Authority's Health Strategy, will remain. These are: Asthma, sexual health, tuberculosis, diabetes, sickle cell and thalassaemia, physical and sensory disabilities, substance misuse, and oral health. This is a comprehensive disease orientated list which, if implemented effectively, will most probably help to improve the health status of the Greek Cypriot community, particularly, as the specific health contracts will hopefully include details on socio-economic, environmental and lifestyle determinants, at national, community and individual levels (DoH 1998). In addition, the Enfield and Haringey (E&H)HImP refers to the set of targets which the government has set in order to reduce exclusion and health inequalities. These include: the improvement of access to health and social services to socially excluded people and to black and ethnic minority groups, and the reduction of smoking especially to disadvantaged groups. Two major commitments are made in the E & H HimP:

i. To improve the quality of information in order to allow the identification of needs at ward, community and estate level, and,

ii. To review all existing strategies and plans to ensure that they effectively tackle inequalities in health.

The HImP does not indicate how any of these actions will be monitored and how the outcomes will be measured. Probably the relevant processes and procedures will be developed in due course, but it is clear that this will be a difficult task.

This overarching plan will also need to be converted into local action plans related to the three healthy settings identified by the government: the school (focusing on children), the workplace (focusing on adults) and the neighbourhood (focusing on older people) (DoH 1998). On the one hand, this arrangement may provide a convenient structure for tackling the health issues of different age groups, on the other hand, it appears to be creating artificial barriers which may not be helpful. For example, not all adults work, in fact the level of unemployment for members of minority ethnic groups, who, as discussed in Chapter 5, suffer more inequalities, is much higher than the white majority (Chapter 3). Perhaps the neighbourhood should be the starting place for addressing inequalities, as it is often the place where the signs of exclusion, such as crime, deprivation, homelessness, drug taking and so on, are most noticeable. However, the term *'neighbourhood'* is not synonymous to the term *'community'*, the former focusing on geographical location which may or may not encompass a community, the latter focusing on shared values and a sense of cohesion which may extend geographical boundaries. In terms of the issues surrounding the health status of the Greek Cypriot community, it was suggested above that the large Greek Cypriot community living in Enfield and Haringey, was probably a positive health force for its individual members as it provided important social support. It was also suggested that the health status of the Greek Cypriots needed to be improved. According to Whitehead (1995) four levels of action for tackling inequalities in health seem to have emerged:

a) strengthening individuals,
b) strengthening communities,
c) improving access to essential facilities and services, and,
d) encouraging macroeconomic and cultural change.

It is evident that whilst the Greek Cypriot is a fairly strong community, its individual members need to enhance their knowledge, motivation and skills in order to alter their behaviour and improve their health status. The *'partnership model'* if applied to health promotion, will involve the Greek Cypriots in the tailoring of appropriate

programmes. Whitehead (1995) argues that interventions at levels c) and d), which are clearly focusing on structural factors, will benefit everyone.

HEALTH ENHANCING AND HEALTH HARMING BEHAVIOURS

Findings and comparisons with other groups

The interconnecting nature of health and illness has already been alluded to in the discussion about health and illness beliefs. Such a relationship exists in the health enhancing and health harming behaviours. As Radley and Billig (1996) have argued:

> *'...health and illness are not merely oppositional terms defining states about which individuals have discrete attitudes. Instead, these ideas have a double existence. On the one hand, they are the means by which we can maintain and define our fitness for society; on the other, they portray a world of experience that we claim for ourselves alone.'*
>
> (p237)

It is with this double existence in mind that the relevant findings will be reported in this section.

Participants of this study, particularly those in the older age groups who tended to be first generation migrants, reported that one of their health enhancing behaviours is the use of traditional remedies (*'practica'*). They reported that they often use *'practica'* as a first line of treatment, either whilst waiting to see the doctor or instead of seeing him/her. For minor ailments these were usually sufficient, but if the problem persisted then they would visit the doctor. Using *'practica'* is one way of maintaining control of one's health. For many these remedies were tried and trusted methods of dealing with ill health or of preventing it, and it went some way to balance out the implied absence of trust between themselves and their doctor. However, key informants reported this practice as a health harming behaviour, calling it characteristically as

'yiatrosophia', a derogatory term meaning meddling with various traditional remedies, which in their view were not scientific. Practicing *'yiatrosophia'*, delayed people from obtaining proper medical help which resulted in the deterioration of one's health problem.

As discussed in the *'health and illness beliefs'* section of this chapter, the family is seen both as a therapeutic and as a pathogenic force. Outside the family the existence of other social support systems was considered important. Participants reported that one of their health enhancing behaviours was to discuss their health and other problems with a family member or a friend. Almost 86% of the survey respondents were found to use these social networks. However, some health harming behaviours were also accredited to the family. Excessive smoking and drinking were reported as means of overcoming stress which resulted within the family. There was some reporting of wife abuse, both physical but particularly psychological.

Working too hard was seen as a health harming behaviour. Attitudes to work, held by first generation migrants seem to have a continuing influence within the Greek Cypriot community. Having migrated to avoid poverty, they entered into a new cycle of deprivation in a foreign country; they had to work long and often unsociable hours, something which has, in many cases a negative effect on the family. Working within their ethnic economy, many first generation Greek Cypriots remain unable to speak English (or speak very little), a situation which creates problems in terms of their understanding of health maintenance and health promotion information. Although employment may have cultural links, the effects of structural links cannot be discounted. It was reported in Chapter 3 that the level of unemployment amongst minority ethnic groups is higher than the white majority. Detailed national or local data about the Greek Cypriots living in Enfield and Haringey, are not available. However this study found that in 1995, 7.5% of the survey participants reported to be unemployed as compared to 7% in the NHLS 91, and 5% in the HSE 91 (Chapter 8). Work (or the lack of it), was the number one cause of stress reported by the survey respondents, 64% of whom reported to be under too much stress. The type of work, was also reported as health harming. For example, women working on the

sewing machine for long hours reported back problems, weight gain, digestive problems, musculo-skeletal problems, depression and so on (Chapter 7, and Papadopoulos and Worrall 1996).

The survey found that 33% admitted to harmful behaviours such as smoking, working long hours and having a poor diet. A smaller number reported to be drinking excessively and not taking any physical exercise. This was confirmed by finding that 60.5% lead sedentary lives and 32% smoke. Despite these findings, 51% reported to engage in health enhancing activities such as taking physical exercise, eating a healthy diet, and staying happy. Some reported that they had reduced their smoking and drinking alcohol, that they are taking vitamins and prescribed medicine. The findings point to a variance between perceived levels of exercise or what constitutes a healthy diet, and recommended measures of exercise or types of diet, something which is further discussed in Chapter 8.

The NHLS 91 found that the overall levels of physical activity are very low. Of their respondents 36% reported to be smoking, 20% fell within the *'increasing risk'* category of alcohol consumption whilst 3% drank hazardously. Forty two per cent reported to have tried stop smoking and 28% had changed to a healthier diet.

The HSE 91 found that 28% of the population smoke. From them 28% wish to give it up. The HEA 94 reported a much lower figure (17%) but this ranged between 23% for the Bangladeshi population and only 10% for the Indian population in their sample. Amongst those who smoke nearly 68% wish to give it up. Six per cent of their respondents were found to be problem drinkers.

Blaxter (1990), in her extensive analysis on health and lifestyles reported that the four main health enhancing/health harming behaviours were smoking, diet, lack of exercise and drinking, but concluded that although behavioural habits are certainly relevant to health, they are perhaps less so than the geographical region, the socio-economic circumstances, the social structures and support, in which they are embedded. All

these, are similar to the findings of this study about the central role of the family, social support networks and employment.

Helman (1990) reports that in most societies people suffering from physical discomfort or emotional distress have a number of ways of helping themselves. In modern societies people tend to use a mixture of home remedies, advice from friends or relatives, advice from an alternative therapist, as well as advice from their doctor. He identifies three overlapping sectors of health care: the popular sector (made up of lay knowledge and beliefs), the folk sector (made up of sacred or secular knowledge and beliefs) and the professional sector. The use of *'practica'* by the Greek Cypriots falls within the popular sector although some references were made to asking the priest to say prayers in the belief that bad or evil spirits which may cause ill health will disappear (folk sector).

Kelleher and Islam (1996) in a study of Bangladeshi people with non-insulin dependent people living in London found that many of them were using traditional foods such as karella to control their diabetes. Their challenge was to integrate their traditional Muslim beliefs about food with the diets prescribed by their doctors.

Current health professionals' understanding and service provision

The findings of the survey reveal that many of the Greek Cypriots are not receiving the advice which they need from the health professionals they are mainly in contact with. Of the 147 of them who responded to a question which sought to find out whether or not they had visited their doctor in the last twelve months, only eight (n=8) replied that they had not. They reported that the most frequent advice they were given was to rest and relax more, followed by advice to change their diet and to lose weight.

However, of those who were categorised as overweight or obese, just over 79% were not given dietary advice and were not advised to take more exercise. Of those who did not achieve their target level of physical activity, just over 83% were not advised to take more exercise. Of those who reported high levels of stress, 69% did

not receive advice to rest more and 80% were not advised to take exercise as a method of reducing stress. Sixty per cent of occasional and regular smokers did not receive advice on how to stop smoking whilst four (n=4) respondents who reported to have been given advice to drink less alcohol, had all reported their drinking to be within safe limits. Furthermore the study revealed that any advice giving was done by the doctor. Whilst some GP practices may not have nurses attached to them, many do, and it was disappointing to discover they appear to be doing very little health promotion.

These are worrying statistics. Lack of advice may be due to lack of time on behalf of busy GPs. However, it may also be due to lack of interest on behalf of the GPs who may also have a stereotypical view of their Greek Cypriot patients as non-compliant, something which was referred to during the interviews with health care providers. It is important not to generalise on the basis of comments given by a small number of individuals. There is nonetheless, an incongruence between the general satisfaction expressed by the Greek Cypriots who took part in this study, and their reported relative frequent use of *'paying to see a doctor of their choice'*. The main reason given for this was to seek a second opinion, which indicates a lack of trust for the opinion of their GP. Other reasons given were: *'my doctor does not believe I am ill'* and *'my doctor does not understand me'*. Many examples of this lack of trust and understanding were given by the Greek Cypriot women who took part in the study which specifically focused on primary health (Papadopoulos and Worrall 1996). A 37 year old woman reported that although she has a language problem she is ashamed to admit it to the doctor. When he speaks fast or in complicated sentences she pretends she understands. A 45 year old woman visited the doctor because she was having dizzy spells. He told her that she was *'putting it on'*. Another 45 year old woman was told by her doctor, before she even had a chance to explain her problem, that *'your problem is that you are too fat. All Greek women are the same, you eat too much'*.

Implications for policy and practice

Communication lies at the heart of establishing trusting relationships. It is generally accepted that communication between people from minority ethnic groups and health care providers remains a major problem (Hopkins 1993, Ahmad 1995). However, this is more than the existence of language barriers. Sheldon and Parker (1992) and Ahmad (1995) state that lack of communication, often reflects inadequate cultural understanding and sensitivity on behalf of the health professionals. Even at the basic level of language, this study uncovered major gaps. The health providers and purchasers who took part in this study, reported varying levels of interpreter availability. In terms of availability in General Practices, this is virtually non existent.

It can be argued that lack of communication can result in ineffective, inappropriate and insensitive care. Such care, wastes valuable resources and, as discussed in Chapter 5, it is also discriminatory. Most of the participants in this study, irrespective of their mastery of the English language, expressed the wish that more Greek Cypriots should enter the health caring professions. As it has already been reported above and in Chapter 7, the reason for this, is mainly one of cultural understanding.

The evidence presented in this area of *'health enhancing and health harming behaviours'* of the Greek Cypriots, strengthens the case for cultural competence training for health professionals which has already been discussed. The evidence in this and previous sections, points also to the need for more effective health promotion strategies. Bhopal (1991) argues that health educators often believe the health education needs of minority ethnic groups are different from those of the majority, but that the relevant techniques are not, whereas in reality the opposite is often the case. Smaje (1995) states that this has clear policy implications, yet it is not always easy to determine the optimal form of intervention, since health professionals often lack the appropriate information about:

> *'...the community's views and aspirations; on their reactions to and intuitions regarding proposed methods, actors and settings; and on the effects of interventions,*

not only in terms of changes in the target behaviour, knowledge or ill health , but also in terms of their effects on wider and cultural aspects of the community's life'

(Bhopal and White 1993, p.149)

Health promotion, at primary health level, is and will continue to be very important. The *'New NHS - Modern, Dependable'* (1997) stated that primary care professionals:

'...understand the patients' needs and they deliver most local services. That is why they will be in the driving seat in shaping local health services in the future. New Primary Care Groups will be established in all parts of the country to commission services for local people'

(para 5.1)

The main functions of Primary Care Groups (PCGs) will be to:

⇒ contribute to the development of HImPs, ensuring that these reflect local needs,
⇒ promote the health of the local population,
⇒ commission health services relevant to their populations,
⇒ monitor performance against the service agreements they have with NHS Trusts.

Clearly the government is placing a heavy reliance on PCGs for bringing about health improvements and the elimination of health inequalities. Whilst they acknowledge that it may be some time before some of these changes will take roots, and that staff development will need to take place, it could be argued that they have started from an unrealistically high level of confidence about the knowledge and skills of the primary care professionals. This study, has revealed that whilst general health knowledge is applied to the needs of the Greek Cypriots in Enfield and Haringey, the level of specific knowledge about the beliefs and health status of the largest minority

community in this area is absent. Furthermore, there appear to be communication barriers, which need to be overcome first, before attempting to tackle anything else.

SUMMARY

This chapter provided a critical review of the main findings of this study which were reported and discussed primarily in Chapters 7, 8 and 9. The review identified four major areas which were investigated in this study: a) beliefs about health and illness, b) health and illness knowledge and views, c) self assessment of health status, and d) health enhancing and harming behaviours. These were analysed in terms of comparisons with other studies, in terms of the current health professionals' understanding and service provision, and in terms of their implications for policy and practice.

The last chapter of this thesis discusses the contribution of this study and some recommendations for further research.

CHAPTER 11
CONTRIBUTION OF THE STUDY AND RECOMMENDATIONS FOR FURTHER RESEARCH

INTRODUCTION

This final chapter is divided in two short parts. The first part deals with the contribution of this study whilst the second part makes a number of recommendations for further research. The reader is reminded that Chapter 2 addressed the limitations of the study, which provide the background to the statements about its possible contribution and the motivation behind the recommendations for further research, which will be made here.

THE CONTRIBUTIONS OF THE STUDY

Based on the data presented in the previous ten chapters of this thesis, it could be argued that this study has made a modest contribution in the following ways:

⇒ Extending the debate of multi-culturalism versus anti-racism,
⇒ Exploring a new field of study,
⇒ Providing insights into the health and lifestyles of a number of Greek Cypriots,
⇒ Considering the ability of health purchasers and providers to respond to the health needs of the Greek Cypriots under study,
⇒ Contributing to the *'new epidemiology of health'* (Coote and Hunter 1996).

The multi-cultural and anti-discriminatory ideology

This study considered the literature around the two main ideological positions which thus far underpinned the analysis of health and minority ethnic groups. The study

went on to propose and argue that neither multi-culturalism nor anti-racism adequately deal with the contemporary complexities of multi-ethnic Britain, and that a new unified position has begun to emerge and take roots. The new approach has integrated the health needs of minority ethnic groups within a broader agenda which is centred around the eradication of inequalities and the promotion of citizenship rights, responsibilities and involvement, whilst at the same time acknowledging that culture is an important active social process.

A new field of study

Despite their limitations, the findings of this study and their analyses, are a unique and original contribution to the understanding of the health and ill health of this population. This thesis has opened the field of study around the Greek Cypriot community living in Britain. The qualitative and quantitative data obtained, as well as the research approaches used in this study, could either be used by other researchers as a base line for comparisons or as platforms from which they can go on to explore in more detail health aspects of this group's health.

The health and lifestyles of the Greek Cypriot community

This thesis has provided for the first time, two main insights into the health of the Greek Cypriot community. Firstly, it has provided a rich description of how Greek Cypriots, conceptualise and express health and illness. It has also provided analyses of their perceived health needs, their self care actions including the use of *'practica'*, and of their views about the health services. Secondly, the study has measured this group's perceived levels of health and fitness, it has considered a number of lifestyle behaviours and their effects, it has assessed the participants' levels of health/illness knowledge, their use and views of the health services, and their perceived need for action. In doing so, it has offered comparisons with two other studies one of which looked at the population of Newcastle, the other looked at the population of England in general. Although in some instances direct comparisons could not be made, this study does provide the only such comparison and helps to highlight the similarities and differences thus eliminating unfounded assumptions and stereotypes about the health of the Greek Cypriots. Such information will also help those working in the

NHS to plan and provide more appropriate services and provide their staff with relevant training.

The health services ability to respond to the needs of the Greek Cypriots

The study has revealed that health purchasers and providers do not have demographic, epidemiological and cultural information about the Greek Cypriot community. This absence is both the reason for the varying levels of cultural understanding and awareness of this group's health needs and their (the purchasers and providers) failure to provide culturally competent care in many instances. As local planners and providers, they are required to analyse the needs of their populations and therefore they should not only be acting on their own initiative to collect relevant information about their largest minority group (in the area of North London under investigation), but should also be highlighting the need for national action to address the failures of the existing systems.

Contributing to the *'new epidemiology of health'*

Coote and Hunter (1996) have argued that,

> *'A new epidemiology of health should be developed, to understand better why people remain healthy, complementing knowledge about why people become ill'.*
>
> (p.iv)

The same authors point out that until now, the focus of government policy, and consequently that of the health professionals, has been more on disease than on health, more on immediate than on underlying causes and more on the easily measurable than on hard-to-measure factors. However, as discussed in many sections of this thesis, the health status of an individual and of a population is the product of a complex interplay between human beings and their environment. Coote and Hunter (1996) recommend that in order to begin to understand this complex interplay, a paradigm shift for public policy at all levels is needed. Studies which draw on lay experience and which attach importance to such factors as a sense of

meaning, purpose and self could lead the way. It is hoped that this study has made a modest contribution in the emerging paradigm of *'new epidemiology of health'.*

RECOMMENDATIONS FOR FURTHER RESEARCH

There is a need for further research in the following areas:

1. The effects of culture on the first and subsequent generations, on the health and lifestyles of the Greek Cypriots living in Britain.

2. On sensitive issues such as mental health, sexuality and sexual health, coping with loss and bereavement.

3. The family as a central force for health and illness.

4. The effects of chronic illness on the sufferer and their carer/s.

5. Levels of participation of the Greek Cypriots in health policy.

6. The design and delivery of health campaigns aimed at the Greek Cypriots.

7. The most effective ways that health practitioners can learn about the health of the Greek Cypriot people and other minority ethnic groups.

8. The development of culturally competent heath care settings /organisations.

9. The establishment of efficient ethnic monitoring systems which are sensitive to local populations and include minority ethnic groups which are outside the nationally used ethnic categories.

10. The development of evaluation/audit tools and/or indices which health care practitioners can use to measure the level of cultural competence of the care given.

11. Replication study.

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Appendix 1

Dear Friend

Re: Enclosed Questionnaire

I am writing to ask for your help. Over the past three years I have been studying the health of the Greek and Greek Cypriots in Enfield and Haringey and I am now trying to collect further information about this very important topic which should concern all of us.

You are probably aware that our community is the largest minority group in Enfield, representing over 10% of its population as well as being one of the largest minority groups in Haringey.

The Enfield and Haringey Family Health Authority and the New River Health Authority (which covers Enfield and Haringey) have the responsibility to provide health care which is sensitive to the needs of the local population. This is not only common sense, it is a requirement by the goverment.

In order to provide good services and good care to our community, these Health Authorities need to have good information about the health needs of our community. Well, believe it or not, very little such information exists. This is why I believe, it is very important that you take a few minutes of your time to complete this questionnaire and return it to me as soon as possible. With this information I will prepare a report which I will submit to the Health Authorities. This will help our community to get its fair share of appropriate services. You will also be helping me complete my studies, something which I have been working hard for the past three years. I will be for ever grateful to your contribution and I hope you will notice the difference in health provision in the years to come.

If you have any questions about this survey or would like to speak to me about anything related to this study please do not hesitate to contact me either by telephone during the day on 081 887 4103 or by writing to me at the address above.

I have enclosed a stamped addressed envelope for your completed questionnaire. May I thank you once again and urge you to complete the questionnaire and not to put it in the bin. IT IS IMPORTANT! Finally, let me assure you that all information will be treated in the strictest confidence and it will not be linked to you or your family in any way.

Yours faithfully

Rena Papadopoulos, MA, BA, RGN, RM, NDN Cert, DipN, DipNEd.

Appendix 2

ΠΑΡΑΚΑΛΩ ΜΗΝ ΠΕΤΑΞΕΤΕ ΑΥΤΟ ΤΟ ΕΡΩΤΗΜΑΤΟΛΟΓΙΟ.
ΠΑΡΑΚΑΛΩ ΣΥΜΠΛΗΡΩΣΕΤΕ ΤΟ ΚΑΙ ΕΠΙΣΤΡΕΨΕΤΕ ΤΟ ΕΩΣ 25-7-95. ΕΥΧΑΡΙΣΤΩ

RE:Το εσώκλειστο ερωτηματολόγιο.

Αγαπητέ συμπατριώτη / συμπατριώτισσα,
Σας γράφω ζητώντας την βοήθεια σας. Τα τελευταία τρία χρόνια έχω αφιερώσει τον καιρόν μου εις την μελέτην της Υγείας της Ελληνικής και Ελληνοκυπριακής Κοινότητας του Λονδίνου, ιδιαίτερα της Κοινότητας του ENFIELD και HARRINGEY, και τώρα προσπαθώ να συλλέξω πληροφορίες πάνω σε αυτό το θέμα το οποίον έχει ιδιαίτερη σημασία για όλους μας.
Πιθανόν να γνωρίζετε ότι η Ελληνοκυπριακή Παροικία είναι η πιό μεγάλη μειονότητα της περιοχής του ENFIELD και αντιπροσωπεύει το 10 τοις εκατό του πληθυσμού της. Επίσης η Ελληνοκυπριακή Παροικία είναι μια από τες πιό μεγάλες μειονότητες του HARRINGEY. Το ENFIELD και το HARRINGEY FAMILY HEALTH AUTHORITY καθώς και το NEW RIVER HEALTH AUTHORITY (το οποίον αντιπροσωπεύει τες δύο περιοχές) είναι υπεύθυνη στον τομέα της Υγείας που είναι μια τόσο ευαίσθητη ανάγκη για τον τοπικό πληθυσμό. Και αυτό δεν είναι μόνον αληθινό, αλλά είναι και μια ευθύνη που επιβάλλεται από την Κυβέρνηση.
Για να μπορέσουν να προσφέρουν καλές υπηρεσίες στην Ελληνοκυπριακή μειονότητα, οι Αρχές αυτές χρειάζονται να έχουν πληροφορείες και στοιχεία όσον αφορά την Υγεία της Κοινότητας μας. Λοιπόν, πιστεψετε, με πολύ λίγες πληροφορίες υπάρχουν όσον αφορά τες ανάγκες Υγείας της Κοινότητας μας, και είναι για αυτόν τον λόγο που έχω αναλάβει να διορθώσω αυτήν την έλλειψη, και ειναι γι' αυτόν τον λόγο που ζητώ από εσάς να διαθέσετε λίγα λεπτά από τον καιρό σας, και να συμπληρώσετε το εσώκλειστο ερωτηματολόγιο, και να μου το επιστρέψετε στον φάκελλο που σας στέλλω. Με τες πληροφορίες που θα πάρω από εσάς θα ετοιμάσω μίαν έκθεση την οποία θα παρουσιάσω στες Αρχές αυτές. Η Εκθεση αυτή θα βοηθήσει τες υπεύθυνες Αρχές Υγείας να προσφέρουν πιο κατάλληλες και πιο αποτελεσματικές υπηρεσίες στην Παροικία μας. Παράλληλα θα βοηθήσετε και εμένα προσωπικά να συμπληρώσω τες μελέτες μου πάνω σε αυτό το θέμα το οποίον με απασχολεί εδώ και τρία χρόνια,
θα είμαι υπόχρεη για την βοήθεια σας και είμαι σίγουρη ότι οι πληροφορίες που θα μου δώσετε θα γίνουν η απαρχή για μια καλύτερη κατανόηση των προβλημάτων Υγείας που απασχολούν την δική μας Κοινότητας, και η βάση για μια καλύτερη Υγιεινή Πρόνοια για την Παροικία μας στο μέλλον.
Εάν έχετε δυσκολίες εις την συμπλήρωση του ερωτηματολογίου μην διστάσετε να επικοινωνήσετε μαζύ μου στο τηλέφωνο 081 887 4103 ή να μου γράψετε στην παραπάνω διεύθυνση.
Εσωκλειω S A E με το ερωτηματολόγιο και σας παρακαλώ να το συμπληρώσετε όσο πιο σύντομα μπορείτε. Δεν είναι ανάγκη να τονίσω πόση μεγάλη σημασία έχει αυτή η μελέτη για τον δικό μας κόσμο. Τελικά σας διαβεβαιώ ότι οι πληροφορίες που θα μου παράσχετε θα χρησιμοποιηθούν με απόλυτη εχεμύθεια.

Σας ευχαριστω

---Ρενα Παπαδοπουλου

FIRSTLY ABOUT YOURSELF

1. **I am** (tick one box only)
   ☐ male ☐ female

2. **My age now** is ..... years

3. **My weight** is .....stones ..... pounds
   OR ..... kilos

4. **My height** is .....feet .....inches
   OR..... metres .....cms

5. Please tick one box: **Are you:**
   - Single ☐
   - Living together as a couple ☐
   - Married ☐
   - Widowed ☐
   - Divorced or Separated ☐

6.(a) Are you still attending school
   Yes ☐ No ☐

(b) What level of education did you/do you attend?
   - Elementary or secondary school ☐
   - College of Arts and Technology ☐
   - College of Further Education ☐
   - Polytechnic ☐
   - University ☐
   - Some other type of College ☐
   (Please specify.....)

7. Were you born in:
   - Cyprus ☐
   - Greece ☐
   - Other ☐

If you were born either in Cyprus or Greece please state how many years you have been
living in England.....

Please use this Table when answering questions -

First generation Greek/Greek/Cypriot:
Someone who was born in Greece or Cyprus from Greek/Greek Cypriot parents and subsequently moved to live in England

Second generation Greek/Greek Cypriot:
Someone who was born and grew up in England and whose parents are first generation Greek/ Greek Cypriots

Third generation Greek/Greek Cypriots
Someone who was born and grew up in England and whose parents are second generation Greek/Greek Cypriots

9. Which of the following best describes yourself:
   Please tick one box only

   a. **First** generation Greek/Greek Cypriot ☐
   b. **Second** generation Greek/Greek Cypriot ☐
   c. **Third** generation Greek/Greek Cypriot ☐
   d. Greek/Greek Cypriot with one parent who is not Greek/Greek Cypriot ☐
   e. Not of Greek/Greek Cypriot ethnic origin ☐

ABOUT YOUR HEALTH

10. Which of the following statements below best describes your usual state of health over the last 12 months?
Please tick one box only

I am very healthy ☐
I am reasonably healthy ☐
I am not very healthy ☐
I am definitely ill, in poor health ☐

11. (a) Do you do anything at the moment to keep yourself heathy or to improve your health?

Yes ☐ No ☐

IF YES - what are the 3 most important things you do to keep yourself healthy or improve your health?

(1).....
(2).....
(3).....

11. (b) Are there any things you do which involve a risk to your health?

Yes ☐ No ☐

IF YES - what are the 3 things you do which involve a risk to your health?

(1).....
(2).....
(3).....

12.(a) Have you ever suffered a heart attack?

Yes ☐ No ☐

(b) Have any of your close relatives, (your parents, brothers or sisters) had a heart attack under the age of 65 years)

Yes ☐ No ☐

(c) Do you suffer from Diabetes? (Only answer yes if you have been told you have diabetes by a doctor).

Yes ☐ No ☐

(d) IF YES - at what age were you told you have diabetes?

Age in years _____

13. Do you have any long-term illness, health problems or handicap?

Yes ☐ No ☐

IF YES

(a) What is the nature of your health problem?

.....
.....
.....

FOOD

These questions are about the food you eat and your views about your diet

Please put a tick for each food listed below to show how often you usually eat it:

	Most days	About once a week	About once or twice a month	Rarely or never
14. MEAT				
Beef, pork or lamb (include mince, bacon and ham)	☐	☐	☐	☐
Chicken or other poultry	☐	☐	☐	☐
Sausages, Tinned meats, Beefburgers etc.	☐	☐	☐	☐
15. FISH				
White fish (eg. cod, haddock, or plaice etc)	☐	☐	☐	☐
Oily fish (eg. tuna, kippers,herring, mackerel, salmon)	☐	☐	☐	☐

	Most days	About once a week	About once or twice a month	Rarely or never
16. RICE, PASTA, PURGURI	☐	☐	☐	☐
17. VEGETABLES				
Salad vegetables	☐	☐	☐	☐
Boiled vegetables	☐	☐	☐	☐
Beans and Lentils	☐	☐	☐	☐
18. FRIED FOODS				
How often do you eat chips or other fried food?	☐	☐	☐	☐
19. FRESH FRUIT	☐	☐	☐	☐
20. CAKES, BISCUITS, SWEETS, ICE-CREAM	☐	☐	☐	☐

21. CHEESE AND OTHER DAIRY PRODUCTS

Cheddar Cheese, Hallumi or Anari	☐	☐	☐	☐
Cottage cheese or other low fat soft cheeses	☐	☐	☐	☐
Low fat yogurt	☐	☐	☐	☐
Full fat Greek yogurt	☐	☐	☐	☐

22. BREAD, CRISPBREAD & CRACKERS

Which of the following do you eat ***most?***

Please tick one box only

WHITE breads, rolls, pitta bread or crackers ☐

WHOLEMEAL bread, rolls, pitta, crackers or crispbread ☐

I don't eat bread, crispbread or crackers at all ☐

23. BUTTER & MARGARINE

Which of the following do you eat ***most?***

Please tick one box only

Butter ☐

Hard margarine (eg. Krona) ☐

Polyunsaturated vegetable margarine (eg. Flora, soya or sunflower) ☐

Low fat spread (eg. Gold, Outline, Delight) ☐

I don't eat butter or margarine at all ☐

24. TYPES OF MILK

Which of the following do you usually have?

Please tick one box only

WHOLE OR FULL CREAM (silver or gold top pasteurised, sterilised, long life or powdered) ☐

SEMI-SKIMMED (red striped top, pasteurised, sterilised, long life or powdered) ☐

SKIMMED (blue top pasteurised, sterilised, long life or powdered) ☐

I DON'T DRINK milk at all ☐

25. EGGS

How many eggs do you usually eat in a week (including boiled, fried,poached, scrambled etc.)

Number of eggs per week ____

HOW OFTEN DO YOU EAT TRADITIONAL GREEK FOOD:

	Very Often	Often	Never
26. **KEFTEDES, KEBABS, SHEFTALIA, MOUSSAKA**	☐	☐	☐
27. **FASOLIA, LOUVI, SOUPS**	☐	☐	☐

28.(a) Are you on any sort of diet for health reasons?

Yes ☐ No ☐

IF YES -

(a) What are the reasons? .....

.....

.....

.....

(b) Are there any kinds of food that you do not eat or drink because of your health (eg. allergies), beliefs or circumstances (eg. religious, vegetarian, etc.)?

Yes ☐ No ☐

IF YES -

What types of food do you not eat or drink?

Please list them here:

.....

.....

.....

29. Have you changed what you eat in the last year?

Yes ☐ No ☐ ***(Go to question 30)***

IF YES - Please indicate the main reason for changing what you eat:

Please tick one box only

Mainly for your appearance (eg. improve your figure) ☐

Mainly for medical reasons (eg. doctors advice) ☐

Mainly for health reasons (eg. eat 'healthy foods') ☐

Mainly to save money ☐

Mainly for other reasons ☐

(Please state.....

.....)

30. Do you think that you eat a healthy diet?

Yes ☐ No ☐

31. There are a number of ideas about why people get certain illnesses. In this question I would like your opinion. Do you think that any of the following health problems are related to what we eat? Please tick one box for each problem

	YES	NO
Lung Cancer	☐	☐
Arthritis	☐	☐
Heart attacks	☐	☐
Diabetes	☐	☐
High blood pressure	☐	☐
Tonsillitis	☐	☐
Constipation	☐	☐
Obesity (overweight)	☐	☐
Bowel cancer	☐	☐
Tooth decay	☐	☐
Gallbladder Stones	☐	☐
Stomach Cancer	☐	☐
Anaemia	☐	☐
Thalassaemia	☐	☐
Breast Cancer	☐	☐
Cataracts	☐	☐

ALCOHOL

These questions are about drinking alcohol. EVERYONE SHOULD ANSWER QUESTION 32 even if you don't drink alcohol

32. How often do you drink alcohol?
Please tick one box

- I have NEVER drunk alcohol ☐
  (Please go now to question 36)
- I USED to drink alcohol but do not drink at all ☐
  (Please go to question 36)
- I drink alcohol once or twice a month or less ☐
- I drink alcohol about once a week ☐
- I drink alcohol 2 or 3 times a week ☐
- I drink alcohol on MOST days ☐
- I drink alcohol EVERY day ☐

33. How would you rate your current alcohol consumption?
Please tick one box only

Are you:
- A light drinker ☐
- A moderate drinker ☐
- A heavy drinker ☐

In answering the next questions, please use the following information:

ONE STANDARD DRINK = ½ pint of Beer
or ½ pint of Cider
or ½ pint of Lager
or 1 glass of Wine, Martini, or cinzano
or 1 small glass of Sherry or Port
or 1 measure of Spirits (Ouzo, Raki, Brandy, Whiskey, Vodka etc.)

A PINT OF BEER, CIDER OR LAGER COUNTS AS TWO STANDARD DRINKS

A DOUBLE MEASURE OF SPIRITS COUNTS AS TWO STANDARD DRINKS

34. In a typical SEVEN day week, including the weekend, how many STANDARD DRINKS of alcohol do you drink?
Please write the number in the space below

I usually drink _____ STANDARD DRINKS of alcohol per week

35. Do you think your present level of alcohol drinking is harmful to your health?
Yes ☐ No ☐

If you are a non-drinker please go to question 37

36. Would you like to change your present level of drinking alcohol ? Please tick one box only
I do not wish to change my present level ☐
I would like to drink less ☐
I would like to stop drinking altogether ☐

37. Do you think that any of the following health problems are more likely to occur in people who drink alcohol? Please tick one box for each problem

	YES	NO
Anaemia	☐	☐
Car accidents	☐	☐
High blood pressure	☐	☐
AIDS	☐	☐
Lung cancer	☐	☐
Stomach ulcer	☐	☐
Chickenpox	☐	☐
Arthritis	☐	☐
Impotence	☐	☐
Liver disease	☐	☐

38. Please answer both (a) and (b)

(a) How much alcohol do you think a man can safely drink a week without damaging his health?
Please write your answer in the space below

A man can safely drink about _____ standard drinks each week

(b) How much alcohol do you think a woman can safely drink a week without damaging her health?
Please write your answer in the space below

A woman can safely drink about ___ standard drinks each week

ACTIVITY AT WORK AND LEISURE

39. Which of the following best describes your daily work or other daytime activity that you usually do? Please tick one box only

- I am usually sitting and do not walk about much
- I stand or walk about quite a lot and do not have to carry or lift things very often
- I usually lift or carry light loads, or have to climb stairs or hills often
- I do heavy work or carry heavy loads often

40. Which of the following best describes what you were doing last week? You may tick more than one box.

Last week I was:

- Working for an employer full-time (more than 30 hours per week)
- Working for an employer part-time (less than 30 hours per week)
- Self-employed or employing other people
- On a government employment or training scheme
- Waiting to start a job I had already accepted
- Unemployed and looking for a job
- At school or in other full-time education
- Unable to work because of long-term illness or disability
- Looking after the home or family
- Other (Please specify.....)

LEISURE TIME activities (not paid work)
Please refer to this table when answering questions 41

List 1 - Light Activity	List 2 - Moderate Activity	List 3 - Strenuous Activity
• Ballroom dancing • Light gardening or do-it-yourself • Housewok • Fishing • Walking • Yoga • Any other activities of asimilar intensity (Please specify)	• Cycling • Disco dancing • Aerobics • Heavy gardening or Do-it-yourself • Golf • GymnasticJ ogging • Swimming • Tennis • Any other activity of a similar intensity (Please specify)	• Basketball • Football • Competitiv e running • Rugby • Hookey • Boxing, wrestling or • martial arts • Weights or weight • training • Squash • Any other activity of a similar intensity (Please specify) ....

41. In the last 2 weeks ending yesterday, how many times did you take part in:

Light physical activity (anything in List 1) lasting more that 20 minutes at a time

Number of times _____

Moderate activity (anything in List 2) lasting more that 20 minutes at a time

Number of times _____

Strenuous activity (anything in List 3) lasting more that 20 minutes at a time

Number of times _____

42. Compared with this time last year, do you take part in more physical activity, the same amount, or less physical activity in you leisure time? Please tick one box

- More physical activity ☐
- About the same amount ☐
- Less physical activity ☐

43. How do you rate your present physical fitness for your age? Please tick one box only

- Very good ☐
- Good ☐
- Reasonable ☐
- Poor ☐
- Very poor ☐

44. Do you feel you take enough exercise for someone of your age?

Yes ☐ No ☐

IF NO -

(a) Which of the following reasons prevents you from taking more exercise? Please tick as many boxes as you wish

- Lack of leisure time (no spare time at evening and weekends) ☐
- Lack of money ☐
- Lack of transport ☐
- Lack of easily available facilities at work ☐
- Lack of easily available facilities in the community ☐
- Illness or disability ☐
- Lack of motivation ☐
- Other reason (Please specify .....)

(b) If you would like to do more exercise, what type of activity or activities would you most like to take part in? Please write below

(1).....

(2).....

(3).....

45. There are a number of ideas about exercise and health. In this question we would like your own views.

Do you agree or disagree with each of the following statement? Please tick one box for every statement

	Agree	Not sure/ It depends	Disagree
Vigorous exercise can be dangerous if you are not used to it	☐	☐	☐
Sport is only for fit, young people	☐	☐	☐

	Agree	Not sure/ It depends	Disagree
Regular exercise is important if you want to loose weight	☐	☐	☐
Exercising outdoors is better for you than exercising indoors	☐	☐	☐
Regular exercise can help reduce your risk of heart disease	☐	☐	☐
You need a lot of expensive equipment to get fit	☐	☐	☐
Regular exercise makes you look more masculine	☐	☐	☐
A short walk a day is better than no exercise at all	☐	☐	☐
Pregnant women should not exercise	☐	☐	☐
You can't get fit on you own	☐	☐	☐

SMOKING

EVERYONE SHOULD ANSWER QUESTION 46, even if you don't smoke tobacco.

46. Which of the following best describes you?
Please tick one box only

- I HAVE NEVER SMOKED ☐
  (Please go now to question 54)
- I USED TO SMOKE but do not smoke at all now ☐
  (Please go now to question 47)
- I SMOKE OCCASIONALLY but not every day ☐
- I SMOKE DAILY ☐

47. If you have ever smoked, how old were you when you started smoking?
Age in years ____

Questions 48 to 52 are for SMOKERS only.
EX-SMOKERS please go now to Question 53
and NON-SMOKERS please go now to question 54

48. (a) If you smoke every day, how much on average do you smoke?
Cigarettes per day ____
Cigars per day ____
Ounces of tobacco per week ____

(b) If you smoke occasionally but not everyday, how much on average do you smoke each week?
Cigarettes per week ____
Cigars per week ____
Ounces of tobacco per week ____

49. Which of the following statements most closely describes your views about the amount you smoke? Please tick one box only

- I am happy to stay smoking the same amount I do now ☐
- I would like to cut down a bit ☐
- I would like to cut down a lot ☐
- I would like to give up altogether ☐
- I would like to smoke more than I do now ☐

50. Do you think that the amount you smoke is harmful to your health?
Yes ☐ No ☐

51. Have you made a serious attempt to give up smoking during the last 12 months?
Yes ☐ No ☐

IF YES -
Why did you start to smoke again? Please write down the reason:

.....

.....

52. Have you cut down the amount you smoke in the last 12 months?
Yes ☐ No ☐

Questions 53 is for EX-SMOKERS only.
SMOKERS and NON-SMOKERS please go now to question 54.

53. Please rate the following statements according to their importance for you.

	Very Important	Fairly Important	Not Important
I felt it was bad for my health	☐	☐	☐
It was costing too much money	☐	☐	☐
Pressure from my family or friends who I live with	☐	☐	☐
Advice from a doctor or nurse	☐	☐	☐
I felt it was antisocial	☐	☐	☐
I was not allowed to smoke at work	☐	☐	☐

Questions 54 onwards are for EVERYONE, whether you smoke or not.

54. Do any of the other members of your household, your family or other people you live with smoke at home?
Yes ☐ No ☐

IF YES - How many members of your household smoke at home, excluding yourself?
Please write in the number here: _____

55. Do you think there should be more smoking restrictions, fewer smoking restrictions, or about the same amount in the following places?
Please tick one of the following boxes for each place mentioned

	More Smoking Restrictions	About the same amount	Fewer Smoking Restrictions
on buses	☐	☐	☐
on trains	☐	☐	☐
on aeroplanes	☐	☐	☐
in restaurants & cafes	☐	☐	☐
in cinemas & theatres	☐	☐	☐
in banks & post offices	☐	☐	☐
in all shops	☐	☐	☐
in public houses	☐	☐	☐
in hospitals & clinics	☐	☐	☐
in all enclosed public places	☐	☐	☐
in all public places	☐	☐	☐
in the place where you work or study	☐	☐	☐

56. Do you think that people who smoke are more likely to get any of these medical problems than people who don't smoke? Please tick one box only for each problem

	Yes	No
Heart attack	☐	☐
Bronchitis	☐	☐
Arthritis	☐	☐
High blood pressure	☐	☐
Stomach ulcer	☐	☐
Lung cancer	☐	☐
Diabetes	☐	☐

	Yes	No
Stroke	☐	☐
Tonsillitis	☐	☐
Tooth decay	☐	☐

57. How many cigarettes a day would you think a person would have to smoke before their health was at risk?
Please tick one box only

One to 5	☐
6 to 10	☐
11 to 20	☐
21 to 30	☐
31 to 40	☐
More than 40	☐

58. Do you think that smoke from cigarettes can be harmful to the healthnon-smokers who breathe it regularly (eg. other members of the family, friends and workmates of smokers)

	Yes	No
Harmful to children and babies	☐	☐
Harmful to adults	☐	☐

STRESS IN YOUR LIFE

59. In general, how stressful do you think your life is at the moment?
Please indicate on the scale of 1 to 10 how stressful you think your life is at the moment. Please CIRCLE an appropriate number.

Note: 1 = not at all stressful, 10 = very stressful

not at all stressful	1	2	3	4	5	6	7	8	9	10	very stressful

60. What are the three greatest causes of stress in your life? Please write in your answers below

(a) The greatest cause of stress in my life is:

.....

(b) The second greatest cause of stress in my life is:

.....

(c) The third greatest cause of stress in my life is:

.....

61. How effective do you think each of the following is at reducing stress?

	Very effective	Fairly effective	Not at all effective
Trying to forget your problems	☐	☐	☐
Resting and relaxing	☐	☐	☐
Having a few drinks	☐	☐	☐
Having a cigarette	☐	☐	☐
Visiting the doctor	☐	☐	☐
Taking some exercise	☐	☐	☐
Eating more	☐	☐	☐
Taking tablets	☐	☐	☐
Spending money	☐	☐	☐
Discussing the problem with another person	☐	☐	☐

62. Do you think that stress can contribute to the cause of following illnesses?
Please tick one box only for each illness

	Yes	No
Bronchitis	☐	☐
Stomach ulcer	☐	☐
Diarrhoea	☐	☐
Asthma	☐	☐
Heart attack	☐	☐
Arthritis	☐	☐
Headache	☐	☐
Tonsillitis	☐	☐
Diabetes	☐	☐
High blood pressure	☐	☐

ABOUT YOUR HOME, FAMILY AND SOCIAL LIFE

63. Is the accommodation where you live:
Please tick one box only

- Owned outright by you or your family ☐
- Being bought with a mortgage or loan by you or your family ☐
- Rented from a private landlord ☐
- Rented from the local council ☐
- Rented from a housing association or charitable trust ☐
- Rented or rent free with a job, farm, shop or other business ☐
- Other (Please state.....) ☐

64. How many rooms does your household have for its own use?
Please do not count small kitchens, bathrooms or toilets.
Please do count living rooms,bedrooms, dining rooms,and all other rooms in your accommodation.

The total number of rooms is _____

65. Which of the following do you have the use of in your home?

(a) Please tick one box below

- A bath or shower for use by your household only ☐
- bath or shower shared with another household ☐
- No bath or shower at all ☐

(b) Please tick one box below

- Central heating radiators, storage heaters, warm air or under floor heating in ALL bedrooms and living rooms ☐
- Central heating, radiators, storage heaters, warm air or under floor heating in SOME (not all) bedrooms and living rooms ☐
- NO cental heating radiators, storage heaters, warm air or under floor heating in ANY bedrooms or living rooms ☐

66. This question is about the people who live in your household.
(a) How many persons (over 16 years at last birthday) are living in your home?
There are _____ people, over 16 including myself

(b) How many children (under 16) are there living in your home?

Children aged between 1 and 4 years last birthday _____
Children aged between 5 and 15 years last birthday _____

(c) Is there anyone in your household who is cared for by other members of the household because of:

	Yes	No
Long-standing physical illness	☐	☐
Mental Handicap	☐	☐
Mental Illness	☐	☐

If YES how old is he or she? Age (in years) ____

67. Do you have someone you can count on when you need to talk over problems or make difficult decisions?

No ☐ Yes ☐

If yes, please say who .....

68. Over the last year have you had visitors at home or gone out to meet people, for example, after work, to clubs, religious meetings or visiting friends and family? Tick one box only

- once a week ☐
- at least once a month but not every week ☐
- less than once a month or never ☐

69. Over the last year, have you done any voluntary work? Tick one box only

- not very often or never ☐
- at least once a month but not every week ☐
- once a week - not every day ☐
- every or most days ☐

Please say what type of voluntary work you did, if any

.....

70. Do you think your social life is generally:
Tick one box only

- very satisfactory ☐
- satisfactory ☐
- not satisfactory ☐

71. Do you usually feel: Tick one box only

- very happy ☐
- happy ☐
- not very happy ☐
- very unhappy ☐

ABOUT YOUR HEALTH AND YOUR DOCTOR

72. Please think back to the last time you consulted your family doctor (General Practitioner) about your own health:

(a) How long ago was this?

- Within the last week ☐
- Within the last month ☐
- Within the last 3 months ☐
- Within the last 6 months ☐
- Within the last year ☐

Within the last 5 years ☐
More that 5 years ago ☐
I never consult a doctor ☐

(b) On the last occasion you consulted your doctor, did you: Please tick one box

Speak to your doctor on the telephone? ☐
See your doctor at the surgery? ☐
Have a home visit by your doctor? ☐

73. If there was a free "health check-up" service available at your doctor's surgery or health centre - where you could get help and advice about staying healthy - do you think you would go and use it in the next 12 months?

Yes ☐ No ☐

74(a) In the past 12 months has your family doctor (General Practitioner) invited you to attend the surgery or health centre for a routing health check?

Yes ☐ No ☐

(b) IF YES - Did you attend for a health check

Yes ☐ No ☐

(NOTE the health check may have been carried out by the nurse)

(c) IF YES - who performed the health check

My own GP ☐
Another GP ☐
A Nurse ☐

(d) IF NO - what was the reason for not attending the health check?

Appointment time not convenient ☐
I have no health problems ☐
I need no health advice ☐
Other ☐
(Please state.....)

75. In the past 12 months, how many times have you visited a casualty or accident and emergency department for treatment for yourself?

(a) Number of times _____
(write NIL if you have not visited in the last 12 months)

(b) IF YES- why did you attend a casualty or accident and emergency department?
Please tick as many as apply

For treatment after an accident ☐
Referred by a GP ☐
Unable to see a GP when desired ☐
Other ☐
(please specify.....)

76. In the past 12 months, have you received any of the following advice from your doctor, a nurse, or someone else (eg. at work or another clinic)?

	Doctor	Nurse	Someone else
Take more exercise	☐	☐	☐
Cut down or give up alcohol	☐	☐	☐
Cut down or give up smoking	☐	☐	☐
Eat different types of food	☐	☐	☐
Lose weight	☐	☐	☐
Rest or relax more often	☐	☐	☐
Get a better night's sleep	☐	☐	☐
Use condoms when having sex	☐	☐	☐

77(a) Has your blood pressure ever been measured?

Yes ☐ No ☐ *(Go to question 78 (a))*

IF YES -

(b) When was the last time you had your blood pressure measured? Please tick one box

- During the last six months ☐
- 7 months to 1 year ago ☐
- Over 1 year but less that 3 years ago ☐
- Over 3 years but less that 5 years ago ☐
- Over 5 years ago ☐

(c) Did your doctor or nurse tell you that your blood pressure was higher than normal?

Yes ☐ No ☐

(d) Are you currently taking any tablets for high blood pressure?

Yes ☐ No ☐

78(a) Have you ever had the CHOLESTEROL level (fat level in your blood) measured?

Yes ☐ No ☐

IF YES -

(b) When was the last time you had your cholesterol measured? Please tick one box

- During the last six months ☐
- 7 months to 1 year ago ☐
- Over 1 year but less that 3 years ago ☐
- Over 3 years but less that 5 years ago ☐
- Over 5 years ago ☐

(c) Did your doctor or nurse tell you that your cholesterol level was too high?

Yes ☐ No ☐

The next three questions are for WOMEN only, men please go to question 82

79(a) Are there any women doctors at your GP's surgery?

Yes ☐ No ☐

(b) IF YES - If you want to see a woman doctor, can you always see her?

- For an emergency (on the same day) ☐
- For a booked appointment for any health problem ☐
- For family planning advice ☐
- For a cervical smear test ☐
- For other women's health problems ☐

80(a) Have you ever been invited to have a CERVICAL SMEAR test?

Yes ☐ No ☐ Not sure ☐

(b) IF YES when was this? Please tick one box

- During the last six months ☐
- 7 months to 1 year ago ☐
- Over 1 year but less that 3 years ago ☐
- Over 3 years but less that 5 years ago ☐
- Over 5 years ago ☐

81(a) Have you ever been invited for a breast cancer screening examination (a mammogram or X-ray of your breasts)

Yes ☐ No ☐ Not sure ☐

(b) IF YES when was this? Please tick one box

- During the last six months ☐
- 7 months to 1 year ago ☐
- Over 1 year but less that 3 years ago ☐
- Over 3 years but less that 5 years ago ☐
- Over 5 years ago ☐

82. Using a condom (sheath) is regarded as an important way of protection against AIDS and other infections

(a) Would you avoid using condoms for the following reasons?

	Yes	No	Not sure
Obtaining condoms is too embarrassing	☐	☐	☐
Condoms are too expensive	☐	☐	☐
There are not enough machines when you need to buy condoms	☐	☐	☐
I can't get condoms from my GP on prescription	☐	☐	☐
Condoms reduce sensitivity	☐	☐	☐
My partner would not like it if we used condoms	☐	☐	☐
You look cheap if you carry condoms	☐	☐	☐

(b) In the last year have you used condoms as a method of contraception?

Yes ☐ No ☐

(c) Do you regularly carry condoms to protect yourself against sexually transmitted diseases?

Yes ☐ No ☐

83(a) Do you or any member of your family see private doctors (you PAY to see a doctor of your choice)?

Yes ☐ No ☐

(b) **IF YES** - Why do you/did you pay for a service which is normally provided free?

I wanted a second opinion ☐

I could not see my doctor when I needed to ☐

My doctor does not understand me ☐

My doctor would not prescribe the tests which I thought needed ☐

My doctor would not prescribe the medicine I need ☐

My doctor does/did not believe I was ill ☐

Other reasons ☐
(please state.....)

YOUR VIEWS ABOUT HEALTH AND ILLNESS

84. Do you think there are ways you can reduce your own chances of having a heart attack? Please tick one sentence that is closest to your own point of view.

"Heart attacks can strike for no reason - they just happen. It's chance, fate, or plain bad luck" ☐

"There are reasons why people have heart attacks but we can do nothing about them - for instance, they are inherited, or happen for reasons we don't yet understand" ☐

"There are some steps you can take that might help to cut down on your chance of a heart attack" ☐

"You can definitely reduce your chances of having a heart attack if you follow the right advice" ☐

"Heart attacks could be avoided completely if only we lived our lives in the right way" ☐

85. Heart attacks are one of the reasons why people die younger than expected. How important do you think each of the following is in contributing to a person's risk of having a heart attack. Please tick one box for each line.

	Very Important	Important	Not at all Important
High blood pressure	☐	☐	☐
Fluoride in the water	☐	☐	☐
Eating too much fatty food	☐	☐	☐
Smoking cigarettes	☐	☐	☐
Suffering from a sudden shock	☐	☐	☐
Air pollution	☐	☐	☐
Hard work	☐	☐	☐
Not taking enough exercise	☐	☐	☐
Stress/Stenochoria	☐	☐	☐
Being overweight	☐	☐	☐
Family history	☐	☐	☐
Being diabetic	☐	☐	☐
Unemployed	☐	☐	☐
Not getting enough sleep	☐	☐	☐
Using too much salt	☐	☐	☐
Loneliness	☐	☐	☐
Drinking coffee	☐	☐	☐
Drinking too much alcohol	☐	☐	☐
Not having enough money	☐	☐	☐
Taking the oral contraceptive pill	☐	☐	☐

86. Do you have any views about how we could work towards making the Greek Cypriot Community in Enfield and Haringey more healthy? If you do, please feel free to write your comments below:

.....

.....

.....

.....

FINDING OUT ABOUT HEALTH ISSUES

87. Do you feel you would like to know more about any of the following? Please tick one box for each line

	Yes	No
Eating a healthier diet	☐	☐
Giving up smoking	☐	☐
Cutting down on alcohol	☐	☐
Reducing stress in your life	☐	☐
Getting a better night's sleep	☐	☐
Loosing weight	☐	☐
How to reduce your risk of having a heart attack	☐	☐
How to reduce the risk of getting HIV infections (AIDS)	☐	☐
The plans of the Health and Family Health Authorities for the next year	☐	☐
The plans of the local hospitals and community health services for the next year	☐	☐

88. Finally, it would be helpful for my research into the effects of people's circumstances on their health, if you could tell me something about your average family income.

Would you please tell me which group below best describes your family (household) income **after tax** (ie. take home pay). Please include any allowances, benefits or pensions you receive. Please tick one box only

Total income per year	**(Total income per week)**	
£0 - £ 2,499	(up to £47 per week)	☐
£ 2,500 - £ 4,999	(£48 - £96 per week)	☐
£ 5,000 - £ 9,999	(£97 - £192 per week)	☐
£10,000 - £14,999	(£193 - £288 per week)	☐
£15,000 - £19,999	(£289 - £384 per week)	☐
£20,000 - £24,999	(£385 - £481 per week)	☐
£25,000 - £29,999	(£482 - £577 per week)	☐
£30,000 - £34,999	(£587 - £673 per week)	☐
£35,000 - £39,999	(£674 - £769 per week)	☐
£40,000 - £44,999	(£770 - £865 per week)	☐
£45,000 - £49,999	(£886 - £961 per week)	☐
Over £50,000	(over £962 per week)	☐

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

PLEASE RETURN IT TO ME AS SOON AS POSSIBLE IN THE STAMPED ADDRESSED ENVELOPE PROVIDED

Rena Papadopoulos

Appendix 4

Dear Sir/Madam

Re: The Health Care Needs of the Greek Cypriot Community: A Critical Investigation and Evaluation

I am currently conducting, as part of my PhD study, a research project into the health needs of the Greek Cypriot community living in Enfield and Haringey. I would be extremely greatful, if you could complete the enclosed questionnaire and return it to me by the..... in the self addressed and stamped envelope which is also enclosed. Let me assure you that any information you give will be treated in confidence.

If you wish to have more information about my research, do not hesitate to contact me.

Yours faithfully

I. Papadopoulos, MA (Lon), BA (OU), RGN, RM, NDN Cert, DipN (Lon), DipNEd (Lon)

Appendix 5

The Health Care Needs of the Greek Cypriot Community:
A Critical Investigation and Evaluation

Survey of the Views of Health Services
Purchasers/Commissioners in Enfield and Haringey

NAME:(Optional)

JOB TITLE:

ORGANISATION:

1. Does your organisation/Authority have a mission statement which is communicated to all staff and service users ?

   YES ☐ NO ☐

   If YES, please attach a copy.

2. In your view is your organisation/Authority committed towards commissioning health programmes which are:

   - culturally sensitive to the Greek Cypriot community?
   YES ☐ NO ☐

   If yes, please give examples.

   If no, please state the reasons why.

   - Easily accessible to individuals from the Greek Cypriot community?
   YES ☐ NO ☐

   If yes please give examples.

   If no, please state the reasons why?

   - Providing adequate services to deal with the different needs of the Greek Cypriot community?
   YES ☐ NO ☐

If yes, please give examples.

If no, please state the reasons why.

- Promoting the health of the Greek Cypriot community?
YES ☐ NO ☐

If yes, please give examples.

If no, please state the reasons why.

3. Are people from the Greek Cypriot community involved in the needs assessment processes of your organisation?
YES ☐ NO ☐

If yes, how are they involved?

Please name the individuals and/or organisations involved in these processes.

If no, please state the reasons why.

4. Does the Authority have a health status profile for its Greek Cypriot community?
YES ☐ NO ☐

If yes, what information does it contain?

If no, please state the reasons why.

5. Is information on service provision available in Greek?
YES ☐ NO ☐

If yes please give examples.

If no, please state the reasons why.

6. Are health promotion materials available in Greek?
YES ☐ NO ☐

If yes please give examples.

If no, please state the reasons why.

7. Is the Authority providing resources for an interpreting/advocacy/link work service for the Greek Cypriot clients?
YES ☐ NO ☐

If yes, what is the extent of this service?

If no, please state the reasons why.

8. Do the Authority's contracts include specifications which ensure that services are responsive, appropriate and acceptable to the Greek Cypriot clients?
YES ☐ NO ☐

If yes, how are these specifications being monitored?

If no, please state the reasons why.

9. In your view, is the Authority commissioning adequate services to deal with the special needs of the growing number of Greek Cypriot elderly?

10. In your view, is the Authority providing adequate services to deal with the special needs of the Greek Cypriot women?

11. Please offer any comments which may be of help to this research.

Thank you for taking the time to complete this questionnaire.
Irena Papadopoulos

Appendix 6

The Health Care Needs of the Greek Cypriot Community:
A Critical Investigation and Evaluation

Survey of the Views of Health Service
Providers in Enfield and Haringey

NAME:(Optional)

JOB TITLE:

ORGANISATION:

1. Does your organisation/NHS Trust have a mission statement which is communicated to all staff and service users ?

   Please tick:
   YES ☐ NO ☐

   If YES, please attach a copy.

2. In your view is your organisation/NHS Trust committed towards providing services which are:

   - culturally sensitive to the Greek Cypriot community?
   YES ☐ NO ☐

   If yes, please give examples.

   If no, please state the reasons why.

   - Easily accessible to individuals from the Greek Cypriot community?
   YES ☐ NO ☐

   If yes please give examples.

   If no, please state the reasons why?

   - Providing adequate services to deal with the different needs of the Greek Cypriot community?
   YES ☐ NO ☐

If yes, please give examples.

If no, please state the reasons why.

- Promoting the health of the Greek Cypriot community?

YES ☐ NO ☐

If yes, please give examples.

If no, please state the reasons why.

3. Are people from the Greek Cypriot community involved in the decision making processes of your organisation?

YES ☐ NO ☐

If yes, how are they involved?

Please name the individuals and/or organisations involved in these processes.

If no, please state the reasons why.

4. Does the organisation/Trust have a health status profile for its Greek Cypriot community?

YES ☐ NO ☐

If yes, what information does it contain?

If no, please state the reasons why.

5. Is information on service provision available in Greek?

YES ☐ NO ☐

If yes please give examples.

If no, please state the reasons why.

6. Are health promotion materials available in Greek?
YES ☐ NO ☐

If yes please give examples.

If no, please state the reasons why.

7. Is the organisation providing an interpreting/advocacy/link work service for the Greek Cypriot clients?
YES ☐ NO ☐

If yes, what is the extend of this service?

If no, please state the reasons why.

8. How does the organisation ensure that services are responsive, appropriate and acceptable to the Greek Cypriot clients?
YES ☐ NO ☐

If yes, how are these quality indicators being monitored?

If no, please state the reasons why.

9. In your view, is the organisation providing adequate services to deal with the special needs of the growing number of Greek Cypriot elderly?
(Please answer if it applies to the services of your organisation)

10. In your view, is the organisation providing adequate services to deal with the special needs of the Greek Cypriot women?
(Please answer if it applies to the services of your organisation)

11. Is your organisation providing training for its staff to enable them to deliver culturally and linguistically sensitive care to their clients?

YES ☐ NO ☐

If yes, please give examples.

If no, please state the reasons why.

12. Please offer any comments which may be of help to this research.

Thank you for taking the time to complete this questionnaire.
Your help is much appreciated.

Irena Papadopoulos

Appendix 7

Mr Stelios Chiotis
London Greek Radio
Florentia Village
Vale Rd London N4

Dear Mr Chiotis

Firstly, let me introduce myself. My name is Rena Papadopoulos and I am the Director of Research at the North London College of Health Studies, which is an associate College of the University of North London.

Currently, I am conducting a research study into the Health care needs of the Greek Cypriot community in London. I was wondering whether you may consider dealing (in your excellent phone-in programme) with a number of health care related questions.

The way that the NHS operates lately can be summarised as follows:

The purchasers: These are the Health Authorities which are required by the government to assess the health needs of their population and then, buy health services, to satisfy those needs, from Hospitals, and community service providers.

The Family Health Service Authorities (FHSA), are also purchasers but buy appropriate services from General Practitioners (GP), Dentists, Pharmacists etc.

The providers: These are the hospitals, community services such as community nursing and health visiting, chiropody, occupational therapy etc, the GPs, Dentists, and other paramedical services.

Some GPs who are fundholders are both providers and purchasers.

There is certain amount of competition between the services due to the fact that the Purchasers look for value for money which naturally involves the provision of specific and required services. These days the service providers endeavour to provide what the public needs rather than giving the public the services which they already have. Their ability to do this may mean success or failure in gaining the contracts (and thus the money), from the Purchasers.

The purchasers have a second responsibility which is expected of them from the Department of Health. They are required to monitor the quality of the service

provision. Nowadays, much of the information regarding the performance of both the purchasers and the providers may be available to the public; this is one way of ensuring that the public gets what it needs and those who provide it are made accountable for their actions.

In order that this ideal situation is achieved, the Purchasers must know the needs of their local population. My research is part of the New River Health Authority's (Enfield and Haringey) attempts to learn about the needs of the large Greek Cypriot community living in Enfield and Haringey. However, the health needs of the Greek Cypriot community in the UK, are extremely under-researched. It is for this reason that a radio debate with contributions from any Greek Cypriot wishing to take part, would be extremely useful to this research.

Two main questions could be put to your listeners:

1. Do you think that the Greek Cypriots have any special health needs / requirements or problems which need to be taken into consideration by the doctors and nurses?

2. Do you think that the Health Services provided to the Greek Cypriot community are sensitive to their needs?

Hopefully, listeners will ring in expressing their views which will be based on their experiences and will make certain suggestions. It would also be helpful if listeners were to be asked their opinions regarding the best ways which can be used in the future in order that the people who decide which services to provide, become aware of their views.

From my preliminary investigations, it appears that many members of our community have very little awareness of the many and profound changes which are taking place in the NHS. In my view both the LGR and Parikiaki, have an important role to play in informing our community about health issues. A recent study, as well as information provided by the Cyprus High Commission in London, seem to suggest that Greek Cypriots get most of their information from reading newspapers from Cyprus and the Greek London press, from the Greek speaking radio stations and from each other.

Should you be interested in broadcasting this idea I would be extremely grateful to you. I would naturally be very happy to discuss this further with you.

I look forward to your early reply,

Yours sincerely

R. Papadopoulos, MA(Lon), BA(OU), RGN, RM, NDNCert, DN(Lon),
DipNEd(Lon), RNT

Appendix 8

A BRIEF SUMMARY OF THE NEWCASTLE HEALTH AND LIFESTYLE SURVEY 1991 (NHLS 91)

The NHLS 91 is probably the most comprehensive and wide-ranging study of the lives of Newcastle residents to have been performed. The survey aimed to determine the health needs of the people in Newcastle, to research into health status, health-related behaviour, knowledge and attitudes, to raise awareness of health issues, to promote community involvement in setting the agenda for health promotion and to contribute to the Newcastle coronary heart disease prevention programme.

The information was collected using a self administered questionnaire, many of the questions for which were derived from other surveys such as the 1991 census, the General Household Survey, the Welsh Heart Survey, the Oxford Health Life Survey, The Whitehall Studies, the East Cumbria Lifestyle Survey, the Aids Education for Young People Programme, and the Monkton Coking Works Study.

A representative sample of 6407 men and women aged 16 to 74 years was used. Non respondents were sent a reminder after three weeks and at six weeks from the initial mailing. 4139 completed questionnaires were received which represents a response rate of 69%. The survey did not request respondents' ethnicity.

Appendix 9

A BRIEF SUMMARY OF THE "HEALTH SURVEY FOR ENGLAND" (OPCS 1991).

The survey was commissioned by the Department of Health. It is the first in a series of annual health surveys designed to monitor trends in the nation's health. The overall aim of the 1991 Health Survey was to obtain information on important aspects of health relevant to cardiovascular disease and nutrition. This is the first official survey of this type to include people aged 65 and over and it provides important new information on the health of elderly people.

Fieldwork was divided into two elements: an initial visit to the household by an interviewer and a second visit by a qualified nurse. At the first visit, each adult in the household was asked to participate in a health and socio-economic interview, have measurements of their height and weight taken, and agree to a nurse visiting them . At this visit adults were asked to give details of any prescribed medicines they were taking, and to have their blood pressure, demi-span (the distance between the sternal notch and the finger roots with the arm out-stretched laterally, a measurement used as an alternative to skeletal size), and waist and hip circumferences measured. Those aged 18 or over were also asked to provide a blood sample for the analysis of total cholesterol, haemoglobin and ferritin (assessment of iron stores). Pregnant women and adults with known clotting or bleeding disorder were excluded from the blood sample. Pregnant women were also excluded from some other measurements such as weight, waist and hip circumference and blood pressure.

The sample was selected using a multi-stage random probability design, from adults living in private households in England. A total of 3,242 adults (aged 16 or over) completed a full interview. This represents 81% of the eligible sample. 78% had their height measured, 77% had their weight measured, 71% had their demi-span measured, 70% had their waist-hip ratio measured, 70% had their blood pressure measured and 57% provided a blood sample. 95% of the sample described their ethnicity as "white".

Appendix 10

A BRIEF SUMMARY OF THE "HEALTH SURVEY FOR ENGLAND" (SCPR and UCL 1994).

The 1994 Health Survey for England is the fourth in a series of surveys designed to monitor trends in the nation's health. The principal focus of the 1994 survey, like that of earlier surveys , was on cardiovascular disease and associated risk factors. The aims of the Health Survey series are:

- to provide annual data about the nation's health
- to estimate the proportion with specified health conditions
- to estimate the prevalence of risk factors associated with those conditions
- to examine differences between population sub-groups
- to assess the frequency with which combinations of risk factors occur
- to monitor progress towards two Health of the Nation targets relating to blood pressure and obesity.

Interviewing was carried out throughout the year in order to deal with seasonal variation. 15,809 adults aged 16 and over were interviewed (a response rate of 92% of adults in co-operating households or 77% of the estimated number of adults in eligible households). Measurements were also taken similar to those in the 1991 survey.

The survey's findings are reported as follows:

- Psychosocial well-being
- General health, use of services and prescribed medicine
- Blood pressure
- Physical activity
- Eating habits
- Obesity and other anthropometric measures
- Smoking
- Drinking
- Blood analytes
- Combination of cardiovascular disease risk factors